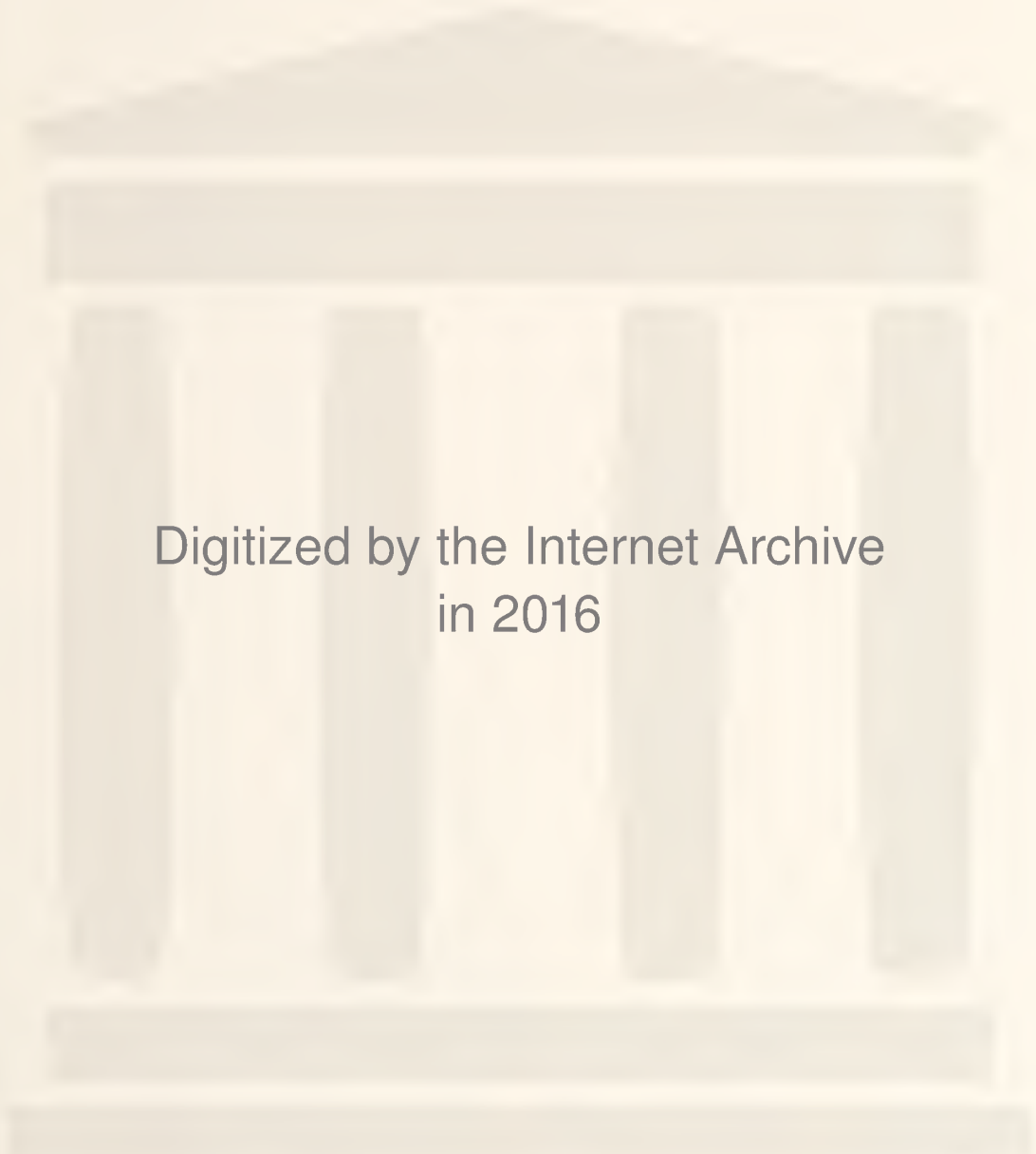
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KMA Legislative Handbook enclosed

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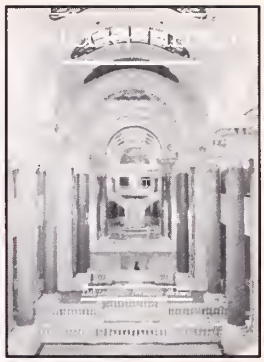
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***COVER:** Refer to the inside cover of the enclosed* **1994 KMA Legislative Handbook** *for detoiled informotion on the outstonding architecture of Kentucky's mognificent Copitol building.*
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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Second-class postage paid at Louisville, KY and additional offices. Yearly subscription rates: $25 domestic; $30 foreign. Single issues $3 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association*, 301 N Hurstbourne Pkwy, Suite 200, Louisville, KY 40222-8512. EDITORIAL AND ADVERTISING: Telephone 502/426-6200.

Listed in Index Medicus. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

National advertising representative: State Medical Journal Advertising Bureau, Inc, 11437 W 106th St, Overland Park, KS 66214, phone 800/788-2360.

The *Journal*, its editors, and the Kentucky Medical Association do not assume responsibility for the opinions and statements of its contributors and advertisers. The *Journal* reserves the right to make the final decision on all content and advertisements.

Printed by the Ovid Bell Press, Inc, Fulton, Missouri 65251.

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Kentucky General Assembly — 1994 —



Wally O. Montgomery, MD

The long holiday season is behind us and the bowl games are over. We look forward to the completion of professional football this month climaxing with the Super Bowl. Now we can concentrate on college basketball and even plan a winter vacation in a warm climate. Our New Year resolves have probably already been broken.

The officers and staff of the Kentucky Medical Association have been preparing for months for their "usual" special winter vacation in Frankfort. The Kentucky General Assembly (KGA) requires a coordinated effort from your state medical association. This session is probably the most crucial in memory.

As you know, legislators refrained from adopting any health measures during the 1991 session. They planned to pass health care reform during a special legislative session in late 1992. This was delayed until May 1993, when the "reform" amounted to a 2% provider tax. The Frankfort Circuit Court has rendered a decision supporting KMA's position that the tax is unconstitutional. The state will probably appeal the decision directly to the Supreme Court.

No matter what happens in the court deliberations, the 1994 General Assembly will probably pass some semblance of health system reform before the session is completed. In addition, we will see the usual massive number of other bills relating to health care.

The KMA legislative agenda will remain constant and our deliberations and decisions will be guided by House of Delegates directives. Each session we attempt to introduce those priorities determined by the House. In most cases, the General Assembly moves very slowly and generally it takes several sessions to achieve passage of legislation. However, we believe that by repetition of our just concerns we will eventually be heard.

Health system reform, liability reform, health and safety measures such as bicycle safety, DUI, boat safety, and seat belt regulations will always be a priority for medicine as we strive for better healthcare for our patients and the citizens of the Commonwealth. We will not compromise our principles — reform is not the sole responsibility of health care providers, and we will make sure every legislator understands our resolve.

As a physician and member of KMA, you must also do your part in preparing your legislator regarding positions of medicine. You will be kept informed by a weekly bulletin highlighting legislative events of the week. Please read the bulletin and know what is happening in Frankfort. Also, read newspaper accounts of KGA activities and watch evening KET presentations which give an excellent synopsis of that day's events.

The Alliance will have a "Legislative Day at the Capitol" in Frankfort in mid-February. Encourage your spouse to attend, and plan to come along if possible. Such attendance will not go unnoticed by your legislator. With our profession and ability to interact with our patients threatened, you may find that a day in Frankfort might be of more interest than the Barnum & Bailey winter headquarters in Florida.

Finally, let me encourage you to contact me, KMA leadership, or headquarters office if you have concerns or questions. Your leadership and staff have the specific function of responding directly to you.

Wally O. Montgomery, MD, FACS
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Improved Plain Film Criteria for the Diagnosis of Bronchiectasis

John H. Woodring, MD, FCCP, FACR

From the Department of Diognastic Radialogy, University af Kentucky Medical Center, Lexington, KY.

Reprint requests to Department of Diognositc Radiology, University of Kentucky Medicol Center, 800 Rose St, Lexington, KY 40536-0084 (Dr Woodring). Phane 606/ 233-5242.

This manuscript establishes criteria that allow more accurate detection of bronchiectasis from plain films. Chest radiographs of 38 patients with proven bronchiectasis were evaluated for seven radiologic signs: bronchial dilatation, identified by visually comparing bronchial diameters in affected areas to bronchial diameters in normal areas an equal distance from the hilum; signet ring sign, with dilated, thick-walled bronchus adjacent to a smaller companion artery; bronchial wall thickening; volume loss; compensatory hyperinflation of surrounding segments or lobes; mucoid impaction of bronchi; and obvious cyst formation. The chest radiograph was abnormal in all 38 cases. Bronchial dilatation was present in 100%, signet ring sign in 79%, bronchial wall thickening in 92%, volume loss in 97%, compensatory hyperinflation in 58%, mucoid impaction in 45%, and cyst formation in 42%. By combining these signs, a very certain diagnosis of bronchiectasis was possible. Measurements of the pulmonary artery-bronchus ratio (ABR) in cases demonstrating the signet ring sign were useful in validating the signet ring sign as a good sign of bronchiectasis on plain films. Overall, the chest radiograph showed 235 (92%) of the 255 bronchiectatic lung segments identified by bronchography or high-resolution computed tomography.

Bronchiectasis is defined as irreversible, abnormal dilatation of the bronchial tree.[1] Although there has been a decline in the prevalence of bronchiectasis since the advent of antibiotics, bronchiectasis remains a problem.[1] Fortunately, with appropriate diagnosis of bronchiectasis and management of superimposed infections, the morbidity and mortality from bronchiectasis may be greatly reduced.[1]

Classically, bronchiectasis results in chronic pulmonary suppuration with recurrent episodes of pneumonia that tend to recur in the same segment or lobe.[1] Unfortunately, most patients with bronchiectasis have nonspecific symptoms, such as cough, sputum production, or hemoptysis, that mimic other chronic pulmonary diseases.[1] For this reason, the diagnosis of bronchiectasis is often difficult to suspect clinically and usually requires the demonstration of chronic, irreversible bronchial dilatation by radiologic means.

So far, no specific criteria have been developed to diagnose bronchiectasis accurately from plain films. For this reason, most authors consider the screening chest radiograph to be of little or no value in diagnosing bronchiectasis.[2-4] Previously, contrast bronchography was considered to be the gold-standard for diagnosing bronchiectasis.[1,3,5] Recently, high-resolution computed tomography (HRCT) has been shown to be as good as bronchography in diagnosing bronchiectasis,[6,7] and has essentially replaced bronchography as a means of diagnosing bronchiectasis. Unfortunately, HRCT is unsuitable as a screening procedure and is usually reserved for those few patients who have a classic history of bronchiectasis. It is likely that many cases of bronchiectasis go undiagnosed and untreated because the disease is often difficult to suspect on clinical grounds and because no criteria have been developed to diagnose the disease with any degree of accuracy from screening chest radiographs. If plain film criteria could be developed that would allow a more accurate suspicion of bronchiectasis, it would be possible to identify a greater percentage of the patients with bronchiectasis who should undergo HRCT for confirmation of the presence of the disease. It is the purpose of this manuscript to establish two simple methods of identifying bronchial dilatation on chest radiographs, and to reevaluate the potential usefulness of the plain film in diagnosing bronchiectasis.

Materials and Methods

The bronchiectasis study group consisted of 38 patients (15 male, 23 female), 1.5-69 years old (average, 29.1 years), with proven postinfectious bronchiectasis. The diagnosis of bronchiectasis was confirmed by bronchography in 32 cases, and was confirmed by high-resolution computed tomography (HRCT), utilizing a 2 mm slice thickness with a 10 mm interscan distance, in 6 cases. Bronchiectasis was classified using the criteria of Reid,[8] and the specific pulmonary segments involved with bronchiectasis were recorded for each case. The erect chest radiographs, obtained at a 6-ft (183-cm) focal-film distance, of all 38 patients were then studied for signs that could be used to detemine the presence of bronchiectasis from the plain films.

For the purpose of this study, two plain film criteria for determining the presence of bronchial dilatation on plain films were developed. First, the presence of bronchial dilatation was determined on plain films by visually comparing the diameters of end-on bronchi in bronchiectatic areas of the lung to the diameters of end-on bronchi in normal areas of lung in the following manner. The erect, posteroanterior chest radiograph was divided into an upper and lower half at the level of the right hilar angle (right and left upper and lower zones, respectively). Bronchi in the affected lung zone were considered to be dilated if they were visibly larger in diameter than bronchi, an equal distance from the hilum and therefore representing bronchi of similar orders of division from the carina, in normal lung zones. In this way, each patient was used as his or her own internal standard by which the presence of bronchial dilatation was judged. When possible, the same zone in the contralateral lung was used for comparison. When that zone was also diseased, a normal zone in either the ipsilateral or contralateral lung was used for comparison.

Second, the signet ring sign, defined as a thick-walled, end-on bronchus being larger in diameter than its companion end-on artery, was also used as a plain film criterion of bronchial dilatation. Since the bronchi and pulmonary arteries run in a shared peribronchovascular connective tissue sheath, and normally are roughly of equal diameter,[9] it is reasonable to believe that documented enlargement of the bronchi relative to their companion pulmonary arteries could be used to confirm the presence of bronchial dilatation on plain films. In cases demonstrating the signet ring sign, the pulmonary artery-bronchus ratio (ABR) was measured. The ABR was defined as the external diameter of an end-on pulmonary artery divided by the external diameter of its companion end-on bronchus. ABRs were measured in the following way. The thorax was divided into an upper and lower half at the level of the right hilar angle. ABRs measured above the reference point were recorded as upper zone ratios, and those measured below the reference point were recorded as lower zone ratios. Paired end-on bronchovascular bundles were identified with the aid of a hand-held magnifying lens (magnification, ×2-×4) and were measured with hand-held calipers and millimeter ruler. Erect posteroanterior chest radiographs, obtained at a 6-ft (183-cm) focal-film distance, were utilized for the measurements. If the signet ring sign was evident in both the upper and lower lung zones of a particular case, then both an upper zone ABR and a lower zone ABR were recorded for that case. However, when the signet ring sign was present in only an upper or a lower lung zone of a particular case, then only a single upper or lower zone ABR was recorded for that case. The minimum, maximum, mean, and standard deviation (SD) values were determined for the upper and lower zone ABRs in the patients with bronchiectasis whose chest radiographs demonstrated the signet ring sign.

The observed upper and lower zone ABRs in the patients with bronchiectasis were then compared to upper and lower zone ABRs measured in a normal control group consisting of 30 healthy subjects (20 male, 10 female), 14-57 years old (average, 30.4 years), with no history of cardiac or pulmonary disease, who underwent posteroanterior chest radiography in the erect position at a 6-ft (183-cm) focal-film distance. In 27 of the normal subjects the chest radiograph was obtained as part of a routine physical examination, and in three the chest radiograph was obtained prior to nonthoracic surgery. One upper zone ABR and one lower zone ABR was recorded and tabulated for each of the 30 normal controls. The minimum, maximum, mean, and SD values of the upper and lower zone ABRs in the controls were then determined. Apparent differences in the mean values of upper and lower zone ABRs between the patients with bronchiectasis and the controls were analyzed with one-way analysis of variance. In individual patients with bronchiectasis, bronchial dilatation was assumed to be present when the measured ABR in the upper lung zone or lower lung zone of one of these patients



was more than 2 SDs below the mean value of ABR for the respective lung zone in the controls.

In addition, the chest radiographs of the 38 patients with bronchiectasis were evaluated for five other radiologic signs previously associated with bronchiectasis.[1, 10] These were: the presence of bronchial wall thickening; volume loss of the affected segment or lobe; compensatory hyperinflation of the surrounding segments or lobes; mucoid impaction of bronchi; and cyst formation with or without contained air-fluid levels.

From the plain films, the specific pulmonary segments involved with bronchiectasis were predicted, and the type of bronchiectasis was also predicted; this was then compared to the bronchographic and HRCT results. In all cases, it was required that the radiologic abnormalities had to be present and unchanged for a minimum of 3 months following the most recent episode of pneumonia in order to indicate that the bronchial dilatation was most likely irreversible.

Results

The chest radiographs of all 38 patients with bronchiectasis were abnormal. Bronchial dilatation, determined by the visual comparison of bronchial diameters in the affected areas to bronchial diameters in normal lung zones, was present in 100% (38/38) of the cases (Figs 1 and 2). The signet ring sign was evident in 79% (30/38) of the cases (Figs 1 and 2).

In the normal controls the upper zone arteries were usually slightly smaller than their accompanying bronchi, while the lower zone arteries were usually slightly larger than their accompanying bronchi. Observed normal upper zone ABRs ranged from 0.63 to 1.14 (mean, 0.85 ±

Fig 1 — (A) Coned view of right upper lung zone from posteroanterior chest radiograph of a 23-year-old male with hemoptysis and a history of repeated right upper lobe pneumonia, shows coarse, crowded bronchovascular markings, bronchial dilatation (arrowhead), bronchial wall thickening (arrowhead), and signet ring sign. The dilated, thick-walled bronchus (arrowhead) forms the "ring" and the smaller adjacent pulmonary artery (arrow) forms the "setting" in the ring, thus producing the signet ring sign; (B) Coned view of normal left upper lung zone of same patient for comparison shows no bronchi of comparable diameter or wall thickness; (C) Right bronchogram demonstrates cylindrical and early varicose bronchiectasis of the apical, anterior, and posterior segments of the right upper lobe.

0.15) (Fig 3), with a range encompassing 2 SDs above and below the mean of 0.55 to 1.15. Observed normal lower zone ABRs ranged from 1.00 to 2.00 (mean, 1.34 ± 0.25) (Fig 4), with a range encompassing 2 SDs above and below the mean of 0.84 to 1.84.

In the 30 subjects with bronchiectasis whose chest radiographs demonstrated the signet ring sign, upper zone ABRs were measured in seven cases and lower zone ABRs were measured in 24 cases. Upper zone ABRs in the subjects with bronchiectasis ranged from 0.17 to 0.70 (mean, 0.43 ± 0.19) (Fig 3). The difference between the upper zone ABRs in patients with bronchiectasis and those observed in normals was statistically significant ($F = 23.78$, $p = 0.0001$). In 5 of 7 (71%) cases the upper zone ABRs were more than 2 SDs below the mean value in normals confirming bronchial dilatation. Lower zone ABRs in subjects with bronchiectasis ranged from 0.30 to 0.83 (mean, 0.58 ± 0.15) (Fig 4). The difference between lower zone ABRs in patients with bronchiectasis and those observed in normals was statistically significant ($F = 169.75$, $p < 0.0001$). In all 24 cases (100%) the lower zone ABRs were more than 2 SDs below the mean values in normals confirming bronchial dilatation.

In addition, bronchial wall thickening was present in 92% (35/38) of the patients with bronchiectasis (Figs 1 and 2); volume loss was present in 97% (37/38) (Fig 2); there was compensatory hyperinflation of the surrounding segments or lobes in 58% (22/38); there was mucoid impaction of the bronchi in 45% (17/38); and obvious cyst formation was evident in 42% (16/38) (Fig 2). Of the 16 cases showing cyst formation on plain films, 7 (44%) had air-fluid levels in the bronchiectatic cysts.

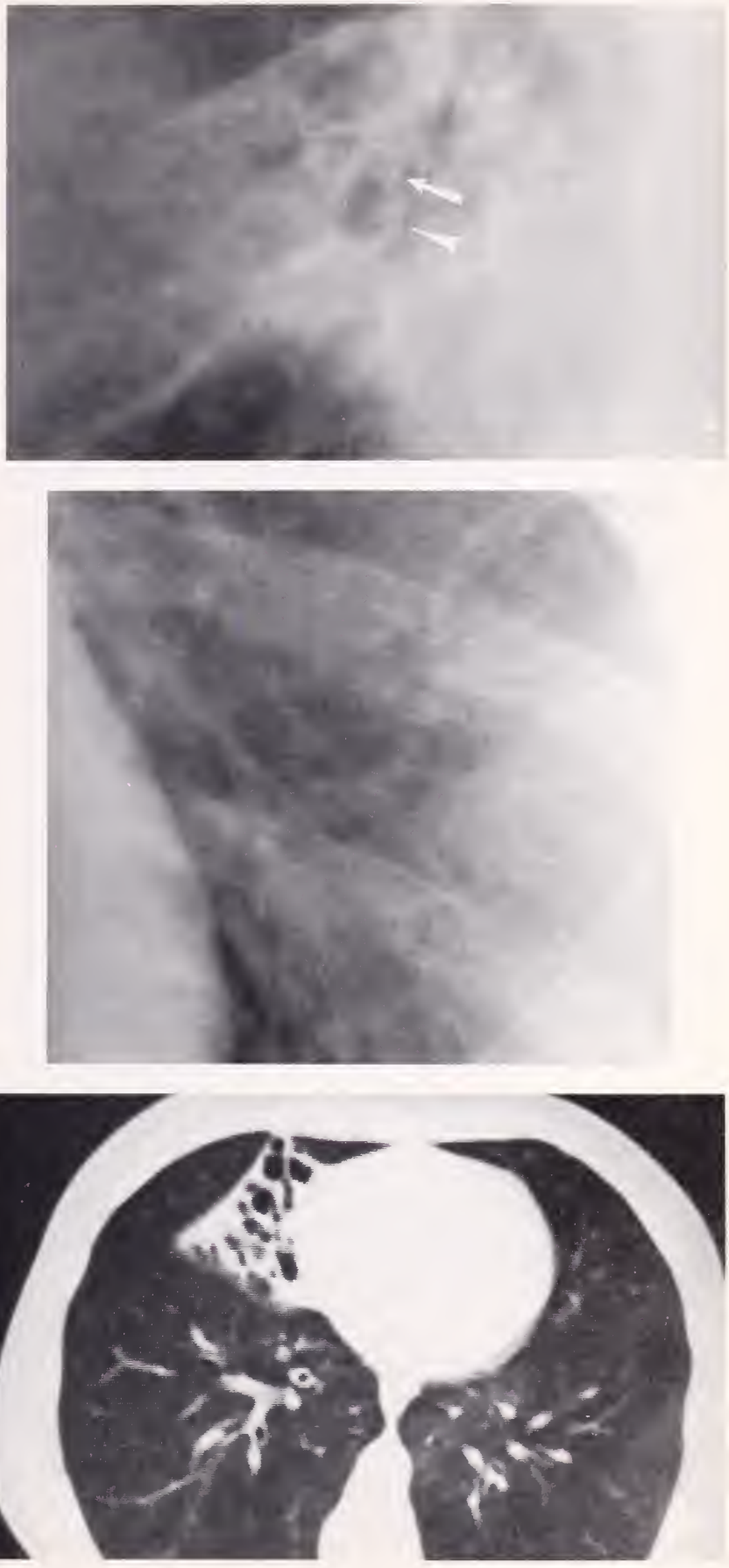
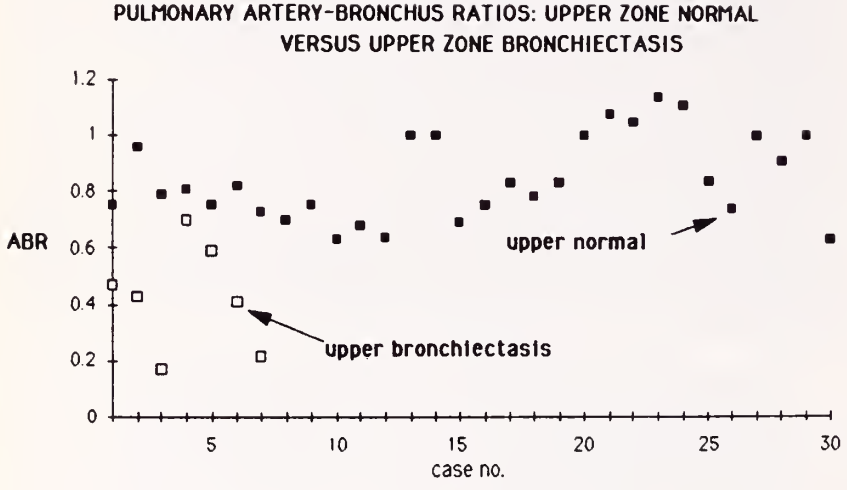


Fig 2 — (A) Coned view of medial right lower lung zone from posteroanterior chest radiograph of a 35-year-old female with chronic cough productive of purulent sputum and a history of multiple episodes of right middle lobe pneumonia, shows bronchial dilatation, bronchial wall thickening, and signet ring sign within a markedly collapsed right middle lobe. Marked bronchial dilatation within the collapsed lobe produces a cystic appearance. The signet ring sign is produced by a dilated, thick-walled bronchus (arrowhead) adjacent to a smaller companion pulmonary artery (arrow); (B) Coned view of normal medial lower left lung zone in same patient shows no bronchi of comparable diameter or wall thickness; (C) High-resolution CT shows collapsed right middle lobe with varicose and cystic bronchiectasis.



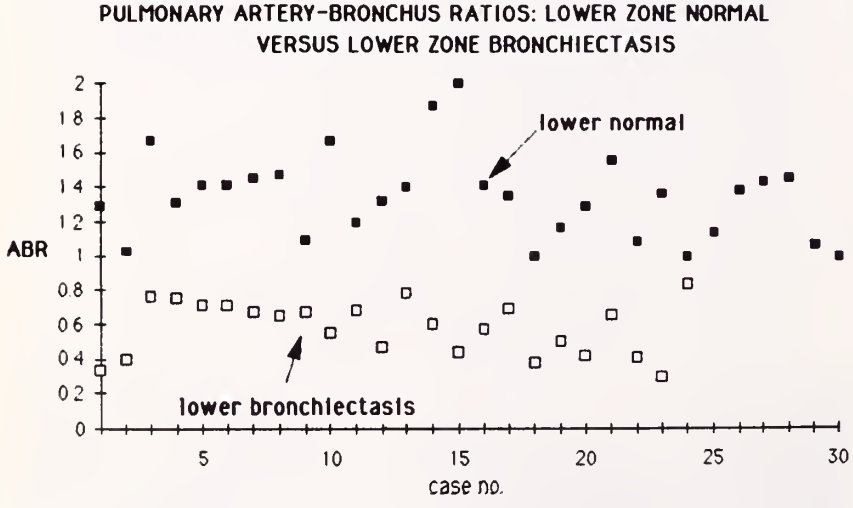


Fig 4 — Lower zone ABRs in normals versus bronchiectasis. Lower zone ABRs in erect subjects with proven bronchiectasis (open boxes) are significantly smaller than lower zone ABRs in erect normal subjects (solid boxes) (mean, 0.58 versus 1.34, respectively), indicating that the bronchi are abnormally dilated.

Bronchography and HRCT in the 38 patients with bronchiectasis demonstrated a total of 255 bronchiectatic lung segments. The segmental distribution of bronchiectasis is listed in Table 1. The chest radiograph correctly predicted the presence of bronchiectasis in 92% (235/255) of these diseased segments (Table 1). The type of bronchiectasis was often mixed, not only within the same patient, but often within the same segment or lobe. Seven patients had cylindrical bronchiectasis only; 6 patients had a mixture of cylindrical and varicose bronchiectasis; 12 had varicose bronchiectasis only; 5 had a mixture of varicose and cystic bronchiectasis; 6 had cystic bronchiectasis only; and 2 had a mixture of cylindrical and cystic bronchiectasis. The chest radiograph was not able to distinguish between cylindrical and varicose bronchiectasis. Although the chest radiograph correctly identified all patients with cystic bronchiectasis, there were some false-positive plain film diagnoses of cystic bronchiectasis in patients with severe varicose bronchiectasis. Of the 20 bronchiectatic segments that were missed on plain films, 15 were involved with cylindrical bronchiectasis, 4 with varicose bronchiectasis, and 1 with cystic bronchiectasis.

Discussion

The results of this study suggest that the conventional chest radiograph can be better at detecting bronchiectasis than is generally appreciated. The ability of the plain film to detect bronchiectasis is greatly enhanced by the establishment of two criteria for determining bronchial dilatation on plain films, namely, the identification of bronchial dilatation by visually comparing bronchial diameters in affected areas of lung to bronchial diameters in normal areas of lung, and the signet ring sign. These two signs, when coupled with the other plain film signs of bronchiectasis including bronchial wall thickening, atelectasis with compensatory hyperinflation of surrounding lobes, mucoid impaction of bronchi, and cyst formation, should allow the identification of most patients with bronchiectasis from plain films alone. Although the precise measurement of pulmonary artery-bronchus ratios (ABRs) from plain films has limited practical value, the comparison of ABRs in patients with bronchiectasis to those in normal control subjects did validate the signet ring sign as a good plain film indicator of the presence of bronchial dilatation.

In this study, the chest radiograph demonstrated definite evidence of bronchiectasis in all 38 patients with bronchiectasis, and showed involvement in 92% of the segments that were shown to be bronchiectatic by bronchography or HRCT. Although the plain film may fail to demonstrate an abnormality in segments that are involved with mild cylindrical bronchiectasis, most segments involved with cylindrical, varicose, and cystic bronchiectasis are abnormal in appear-

ance on plain radiographs when these seven criteria are used. Thus the chest radiograph may be useful in confirming the diagnosis of bronchiectasis in patients who have a classic history of the disease, and in identifying patients with nonspecific pulmonary symptoms who should undergo HRCT for definitive evaluation for bronchiectasis.

The chest radiograph, however, was of limited value in distinguishing among the three types of bronchiectasis. It was not possible to distinguish between cylindrical and varicose bronchiectasis on plain films due to the inability to determine whether or not the bronchus was smoothly dilated or beaded in appearance. Although the chest radiograph correctly identified all patients with cystic bronchiectasis, some patients with severe varicose bronchiectasis also showed cysts on their plain films and were therefore falsely diagnosed as having cystic bronchiectasis.

The differential diagnosis of bronchiectasis on plain films is limited. Unfortunately, bronchial dilatation and bronchial wall thickening are not specific for bronchiectasis, and are often encountered in acute pneumonia and atelectasis.[1,6,11] This form of bronchial dilatation, often referred to as "reversible bronchiectasis," will resolve after resolution of the acute pneumonia or atelectasis.[1,6] In order to determine that bronchial dilatation is irreversible (true bronchiectasis), it is usually recommended that HRCT be done at least 2-4 months after the most recent episode of pneumonia.[1,7] I believe that the same is true of the plain film diagnosis of bronchiectasis. In the setting of an acute pneumonia or acute lobar or segmental atelectasis, the presence of bronchial dilatation and bronchial wall thickening should not be taken as evidence of bronchiectasis. In this study I required that the plain film abnormalities be present and unchanged for a minimum of 3 months following the most recent episode of pneumonia. If, after such a period of time, the plain film signs of bronchiectasis persist, then a more confident diagnosis of true bronchiectasis can be made.

In summary, the chest radiograph can diagnose bronchiectasis with greater accuracy than is generally appreciated. The assessment of bronchial dilatation on plain films is made possible by comparing the diameters of bronchi in affected areas to those in normal areas, and by recognition of the signet ring sign. When these findings are chronic in nature, and are coupled with other signs of bronchiectasis including bronchial wall thickening, volume loss, compensatory hyperinflation of surrounding lobes, mucoid impaction of bronchi, and obvious cyst formation, bronchiectasis can be diagnosed from plain films with confidence; the diagnosis may then be confirmed by HRCT.

Table I. Segmental distribution of bronchiectasis in 38 patients with bronchiectasis confirmed by bronchography or high-resolution CT.

Lung Segment	No. with Bronchiectasis	Positive CXR	Negative CXR
RUL			
apical	7	7	0
anterior	9	9	0
posterior	8	7	1
RML			
medial	19	18	1
lateral	15	14	1
RLL			
superior	12	12	0
anterior	17	15	2
medial	19	17	2
posterior	19	17	2
lateral	19	16	3
LUL			
apical-posterior	2	2	0
anterior	1	1	0
LINGULA			
superior	8	6	2
inferior	11	8	3
LLL			
superior	18	16	2
anteromedial	24	24	0
posterior	24	23	1
lateral	23	23	0
TOTAL	255	235 (92%)	20 (8%)

RUL = right upper lobe, RML = right middle lobe, RLL = right lower lobe, LUL = left upper lobe, LLL = left lower lobe

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Sensory Evoked Facial Muscle Electromyography for the Quantification of Acute Labor Pain

William E. Ackerman III, MD; Peter J.D. Andrews, MB, FFARCS; Mushtaque Juneja, MD; Victoria Cases-Cristobal, MD; Harvey P. Edmonds Jr, PhD; Benjamin R. Rigor, MD

From Departments of Anesthesiology, University of Louisville School of Medicine, ond the Women's Povilion of Norton Hospitol, Louisville, KY 40291.

Dr Ackermon is Associote Professor of Clinciol Anesthesio; Dr Andrews is Instructor in Anesthesio; Dr Junejo is Assistont Professor of Clinciol Anesthesio; Dr Coses-Cristobel is Fellow in Obstetric Anesthesio; Dr Edmonds is Professor of Physiology; ond Dr Rigor is Professor ond Choirmon, Department of Anesthesiology.

Presented in parts ot the Tenth World Congress of Anesthesiologists, June 15, 1992, The Hogue, The Netherlonds, ond ot the Internotionol Anesthesio Research Society meeting, Morch 15, 1992, Son Froncisco, CA.

Reprint requests to 6605 Horrods View Circle, Prospect, KY 40059 (Dr Ackermon).

Assessment of the adequacy of epidural analgesia for acute pain management can be difficult on occasion. This investigation used non-invasive sensory evoked facial muscle electromyography (SEFE) as well as a Verbal Assessment Scores (VAS) to assess severe pain in healthy parturients during the first stage of active labor. Institutional Review Board approval and patient informed consent were obtained from 12 healthy parturients who were in active labor and who had requested epidural analgesia for labor pain. SEFE microvoltage was recorded prior to epidural placement when a patient reported severe pain and again when a patient reported no pain with a subsequent uterine contraction. VAS assessments (0 = no pain and 10 = the worst pain ever experienced) were also recorded at identical time intervals. Statistical analysis was done using the paired two tailed Student's t-test. Each patient served as their own control. A statistically significant decrease in SEFE microvoltage ($p < 0.001$) was noted when analgesia was established (VAS = 0) in each patient. It was concluded in this pilot study that SEFE can be effective in quantifying acute severe nociception and thus can provide a continuous objective indicator of the effectiveness of analgesic regimens in an acute obstetric pain setting. Its applicability in other acute pain areas remains to be investigated.

Clinicians have long recognized the importance of acute pain management. However, the perception of pain is subjective and not always readily available to the treating physician. The clinical assessment of acute pain can be difficult in instances where a patient may be intubated or does not speak the same language as the attending pain practitioner. Pain research is increasing but most clinical investigations rely on visual or verbal analogue pain scores to quantitate and statistically analyze nociceptive responses from qualitative data.[1,2] The quantification of acute pain theoretically could improve treatment by decreasing the incidence of pharmacologic under and/or overdosing. Recently an objective measurement of pain intensity using sensory evoked noninvasive facial muscle quantitative surface electromyography (SEFE) was confirmed to be effective in detecting inadequate anesthesia in patients receiving general anesthesia.[3,4] The purpose of this study was to investigate the ability of SEFE to objectively assess severe pain in healthy, conscious patients and to ascertain if SEFE would exhibit statistically significant microvoltage (mcV) changes when healthy parturients in active labor reported either severe pain and complete analgesia before and after receiving epidural analgesia.

Methods

Following Institutional Review Board approval and patient informed consent, twelve ASA I, Caucasian $Gravida_1$, $Para_0$ patients who requested epidural analgesia for the first and second stages of labor and had not received analgesics or magnesium sulfate 48 hours or less before epidural catheter placement were included in this investigation. An Anesthesia and Brain Activity Monitor (ABM) Datex, Helsinki, Finland, was used for SEFE analysis. Three silver/silver chloride adult surface electrode electrocardiogram patches (3M, St. Paul, MN) were placed on the forehead of each patient, following skin preparation with alcohol to decrease impedance from dead epithelial cells and skin oil, as follows: two surface electrodes placed over belly of the right frontalis mus-

cle 1 cm apart and 1 cm above the right eyebrow and one electrode placed over the right mastoid process. Immediately before SEFE electrode placement and every 1 min thereafter for the duration of this study each patient reported a verbal assessment pain score (VAS) (0 = no pain and 10 = the worst pain ever experienced). VAS scores were recorded every minute throughout this study until each patient reported analgesia (VAS = 0).

Following a loading dose of 10 ml/kg of lactated Ringer's solution epidural analgesia was established using a 17 gauge Tuohy needle placed with the needle bevel positioned cephalad at the L_{3-4} or L_{2-3} interspace. Each epidural catheter was subsequently introduced approximately 2-3 cm into the epidural space. Every epidural catheter was placed with the patient in the sitting position. Three ml of a 2% lidocaine test dose were administered at a rate of 1 ml/30 sec followed by a 3 min latency period. If a patient demonstrated no signs of an intravascular or subarachnoid injection, subsequent epidural catheter dosing was done using 4 ml of 0.5% bupivacaine mixed with 2.5 mcg/ml of sufentanil. Following epidural dosing each patient was placed supine in a left lateral tilt. If a patient reported any pain (VAS > 0) after a period of 5 min subsequent dosing was done with 1 ml of 0.25% bupivacaine/min until a VAS score of 0 was noted following a subsequent uterine contraction verified by internal uterine monitoring. No patient was included in this study if they did not have analgesia (VAS = 0) following the administration of a total volume of 12 ml of local anesthetic. No patient was included in this study unless she reported maximum pain intensity (a VAS score = 10) before epidural dosing. Furthermore, no patient was included in this study if they were febrile or unless uterine contraction pressure exceeded 20 mm Hg measured by internal transcervical monitoring or unless the frequency of uterine contractions at the initiation of this study occurred at a frequency of 3 or more contractions/min with a duration of 30 sec or greater. Each patient's heart rate was continuously monitored with a pulse oximeter. Each patient's arterial blood pressure was monitored every minute with an automatic blood pressure device until analgesia was reported (VAS = 0). Each patient's blood pressure was subsequently monitored every 5 min for 20 min and every 10 min thereafter. Hypotension was defined to be a systolic pressure less than 100 mm Hg or if the baseline systolic pressure was less than 100 m Hg a systolic pressure 10% less than the baseline systolic pressure.

Table 1. Maternal characteristics

Age (yrs)	21.5 (3.1)
Height (cm)	170.5 (11.9)
Weight (kg)	87.4 (18.6)
Gravidity	1
Parity	0
Gestational age (wks)	38.7 (1.9)
Cervical dilatation (cm)	5 (1)
Pre-block pain score (1-10)	10 (0)
Pain score with analgesia (1-10)	0 (0)
Temperature (degrees Centigrade)	37.3 (0.6)
Total volume of anesthetic (ml)	8.3 (1.0)
Hypotension (n/%)	(0/0)

SEFE impulses were preamplified to obtain spontaneous SEFE signals in a range of 0-100 mcV. SEFE signals were filtered by the ABM to attempt to eliminate low frequency movement and 60 Hz power line contamination. Filtered signals were full wave rectified and subsequently passed through a logarithmic amplifier. Following the computation of mean integrated voltage values, SEFE signals were displayed in an analogue format. Numeric SEFE values were displayed every second. Data trending was established by displaying 10 sec data averages as a continuous series of histograms (Table 1). The 10 sec mean digitized values were placed in ASC II code and were converted from semi-logarithmic to nonlogarithmic formats by a microprocessor and were stored in Lotus 1-2-3 files for statistical analysis. Pre and post epidural SEFE and VAS values were statistically analyzed and compared at maximum pain intensity and at the first report of complete analgesia following a uterine contraction using the paired two tailed Student's t-test with each patient serving as their own control. This study was designed through a preliminary investigation to have 80% power to detect a difference of 5 mcV or greater between microvoltage readings associated with severe pain and those associated with no pain. A p value less than 0.05 was used to reject the Null hypothesis.

Results

Twelve ASA I or II primiparae Caucasian females were included in this study. Patient demographic data is presented in Table 1. Each patient served as their own control. Each patient had a VAS =

Table 2. SEFE amplitude pre and post analgesia

QEMG (mcv) when VAS = 10	11.6 (range 9.2-14.1)
QEMG (mcv) when VAS = 0	3.5* (range 2.7-4.3)

* ($p < 0.001$)

10 prior to epidural catheter dosing and a VAS = 0 following a mean local anesthetic volume of 8.3 (0.6) ml. When the VAS equalled 10, the mean SEFE amplitude was 11.6 mcv (range 9.2-14.1 mcv with a coefficient of variation of 23%) (Table 2). When each patient reported analgesia and the mean VAS equalled 0 the mean QEMG amplitude was 3.5 mcv (range 2.7-4.3 mcv with a coefficient of variation equal to 26%) ($p < 0.001$). No patient in this investigation was hypotensive throughout the duration of this study.

Discussion

Clinical pain assessment is an integral part of the process of treating acute pain. This study demonstrated that the SEFE was effective in quantifying acute severe pain and was also effective in evaluating the effectiveness of epidural analgesia in parturients during the first stage of labor. The pregnant patient was chosen for this study because experimental pain did not have to be induced and because pregnant patients have been reported to experience severe pain during labor.[5] Only primiparae patients were included in this study because Melzack et al have reported that pain for the first birth is worse than that for subsequent births in a statistically significant number of patients.[6] Only a single ethnic group was chosen for this investigation because ethnicity has been shown to effect pain perception.[7] Greenwald reported that individuals with different ethnic backgrounds exhibited differences in the interpretation and expression of pain.[7] Patients who were receiving magnesium sulfate or who were febrile were not included in this study because either one may decrease SEFE myopotential activity.[3,4] Facial muscles were chosen for electrode placement to minimize potential electrical interference from the contracting uterus and because the facial muscles were those previously studied to evaluate the adequacy of general anesthesia.[3,4] Myopotentials obtained from the surface electrodes using the SEFE are not the same as activity recorded from needle electrodes inserted in the frontalis muscle. SEFE myopotentials represent the summation of activity from the head, neck, and shoulders.[3] A wide range of SEFE mcV (9.2-14.1) was noted among the patients when severe pain was reported. It is felt that this observation could have been anticipated because the perception of pain may be influenced by differences among patients with respect to psychological and behavioral responses to acute pain, and to the emotional state of each patient at the time of pain intensity measurement.[8] As a result, each patient's baseline mcV with severe pain must be established prior to initiating a SEFE evaluation.

Studies of pain intensity during labor lacked quantification until 1950 when Javert and Hardy used a dolorimeter to induce experimental pain in parturients and compared it with labor pain.[9] Verbal response dependent tests and/or visual assessment scores have been used to assess the severity of labor pain.[10,11] However, these tests can be subject to intrapersonal variation because they used subjective data to assess pain and to statistically analyze qualitative data from subjective responses. Physiologic measurements such as heart rate and blood pressure can habituate rapidly and as a result can make pain assessment difficult.[12] Furthermore, Dowling reported that heart rate may rise in anticipation of pain but not in reaction to the actual pain experienced.[13] The use of evoked cortical potentials to assess severe pain is equivocal at present.[14-17] Because serotonin levels are known to effect pain perception, Selmaj reported that blood serotonin levels were elevated when patients experienced pain.[18] However, there was not a good correlation between the blood serotonin level and the patient's pain perception.[18]

No patient in our study was hypotensive during or immediately following epidural dosing. We attribute this observation to the fact that each patient received adequate prehydration prior to epidural dosing and to the fact that each patient was dosed with local anesthetic based on SEFE as well as on the VAS at which time no further local anesthetic was administered. An interesting observation noted during this investigation in each patient studied was the fact that the SEFE exhibited a significant decrease in microvoltage prior to a uterine contraction and remained decreased with a subsequent contraction when the patient reported analgesia (VAS = 0). This allowed us the ability to precisely dose the local anesthetic through the epidural catheter as opposed to giving a set volume per minute until the patient reported analgesia. When the parturients

in this study were experiencing severe pain, the SEFE baseline between contractions remained elevated.

It is concluded from the results of our investigation that SEFE correlated with both stimulus intensity and the verbal assessment of severe pain in a single pregnant ethnic group. The results of this study are significant because having an objective pain evaluation can aid clinicians in determining optimal pharmacologic dose-response relationships in individual patients and enable one to maximize treatment while minimizing side effects related to overdosage. The continuous display of the SEFE allowed an objective assessment of the adequacy of epidural analgesia during dosing of a local anesthetic and provided a continuous objective indicator of the efficacy of epidural analgesia following epidural local anesthetic and/or local anesthetic/narcotic dosing during the first stage of labor. One might question why one would use the SEFE to assess pain in awake patients especially when a VAS or a visual analogue score could be used to assess nociception. Both of these pain measurements exhibit simplicity, low cost, and ease of administration for repeated measurements in most instances. However, in a high risk obstetric referral center SEFE can be of clinical benefit. The results of this study were clinically applicable at our institution in the assessment of the analgesic response following epidural catheter placement of a Vietnamese patient who did not speak English and was admitted in active labor. We had the limited availability of an interpreter and were able to establish a severe pain SEFE baseline of 10 mcV and subsequently dosed the patient's epidural catheter with cessation of dosing after 7 ml of 0.25% bupivacaine following a downward SEFE microvoltage trend to 4 mcV. The patient received two subsequent redoses; the first at 7 cm dilation and the second for delivery of her baby using SEFE to titrate our epidural dosing as previously stated. The SEFE is noninvasive, simple to use, and offers an advantage over previously mentioned pain measurements in that it provides a continuous assessment as opposed to intermittent evaluations. Consequently one should be able to follow trends of increases in SEFE mcV to predict when epidural analgesic management needs reevaluation.

As previously mentioned, this investigation is a pilot study. Further research is indicated and is in progress to determine the effectiveness of SEFE in acute postoperative pain settings as well as in intensive care settings. It is anticipated that the results of this study as well as those of future investigations will benefit not only anesthesiologists but any clinician evaluating and treating patients suffering with acute pain.

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CAGE Questionnaire

For the Diagnosis of Alcoholism

C = Have you ever felt you should **cut down** on your drinking?

A = Have people **annoyed** you by criticizing your drinking?

G = Have you ever felt bad or **guilty** about your drinking?

E = Have you ever had a drink first thing in the morning (**eyeopener**)?

Positive CAGE Answers:

1 = Suggestive 2 = Probable 3 and/or 4 = Diagnostic

KENTUCKY MEDICAL ASSOCIATION
Committee on Impaired Physicians
301 N Hurstbourne Pky, Ste 200
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Neurogenic Scoliosis in Children

Steven D. Glassman, MD; Gregory B. Nazar, MD; John R. Dimar, MD; Rolando M. Puno, MD; John R. Johnson, MD

From the Department of Orthopedic Surgery, Department of Surgery and Department of Neurosurgery (Dr Nazar), University of Louisville School of Medicine, and the Kenton D. Leathermon Spine Center, Louisville, KY.

Although the majority of scoliosis in juveniles and adolescents is idiopathic, an identifiable etiology does exist in some cases. Nonidiopathic causes of scoliosis include congenital bony anomalies, such as hemivertebral bodies or unilateral unsegmented bars, collagen vascular disorders such as Marfan's syndrome, and neuromuscular disorders such as cerebral palsy, muscular dystrophy, or myelomeningocele. Also, benign or malignant bone tumors, classically osteoid osteoma, can cause a scoliosis. Less commonly scoliosis may be caused by central nervous system abnormalities such as syringomyelia, tethered spinal cord, diastematomyelia, or an intramedullary spinal cord tumor. Scoliosis associated with one of these abnormalities can be termed neurogenic scoliosis. While in some instances the underlying problem may have been obvious from birth or infancy, neural axis abnormalities may remain undetected and the progression of an associated scoliotic deformity may closely mimic the pattern seen with adolescent idiopathic scoliosis. Because the appropriate treatment of neurogenic scoliosis differs significantly from that of idiopathic scoliosis, identification of these unusual cases is critically important.

The purpose of this article is to review the Leatherman Spine Center experience with the presentation, evaluation, and treatment of children with neurogenic scoliosis. As a tertiary referral center for spine deformities, the Leatherman Spine Center assesses approximately 450 new cases referred for evaluation of presumed idiopathic scoliosis each year. Over the past 4 years, 14 children or slightly less than 1% per year have had an evaluation which revealed scoliosis of neurogenic origin. The etiology in these cases has included tethered spinal cord in five cases, diastematomyelia in two cases, syringomyelia in five cases and neural axis tumors in two cases. Although any of these problems may present with a significant neurologic abnormality, all the patients in this series presented with an apparently idiopathic scoliosis as their reason for referral.

Clues which might suggest a nonidiopathic etiology include the age of the patient, a rapid rate of curve progression, abnormal dermatologic or neurologic findings on examination, significant associated pain, or an atypical curve pattern on plain radiographs. Subsequent work-up may include magnetic resonance imaging (MRI) scan, myelogram, and post myelographic CT scan. Despite the availability of sophisticated imaging capabilities, the most useful diagnostic tool is still a high index of suspicion.

Case Reports

Case 1 — A 9-year-old white female was well until several weeks prior to her presentation for complaints of back pain, which was worse at night. Her past medical history was unremarkable, with normal birth history, normal growth and milestones, and no history of neurologic difficulties. No abnormalities in the appearance of her back had been noted during the summer prior to her presentation. When she began to complain of persistent back pain, she was seen by her pediatrician who noted a right thoracic scoliosis, without associated neurologic findings, and she was referred for further evaluation. The patient was premenarchal and gave no history of recent growth spurt.

On physical examination, she was a healthy appearing white female who stood with mild shoulder and pelvic asymmetry. On forward bending, she had a notable right thoracic scoliosis with a moderate rotational component. Her neurological examination was completely normal. Plain radiographs of the spine revealed a 27 degree right thoracic scoliosis (Fig 1A) and a relatively normal sagittal contour on lateral x-ray.

Although the patient presented with a physical examination and radiographic picture consistent with idiopathic scoliosis, two aspects of her presentation were somewhat unusual. First, the patient complained of persistent pain, which is always worrisome in children, and an unusual presenting symptom in cases of idiopathic scolio-

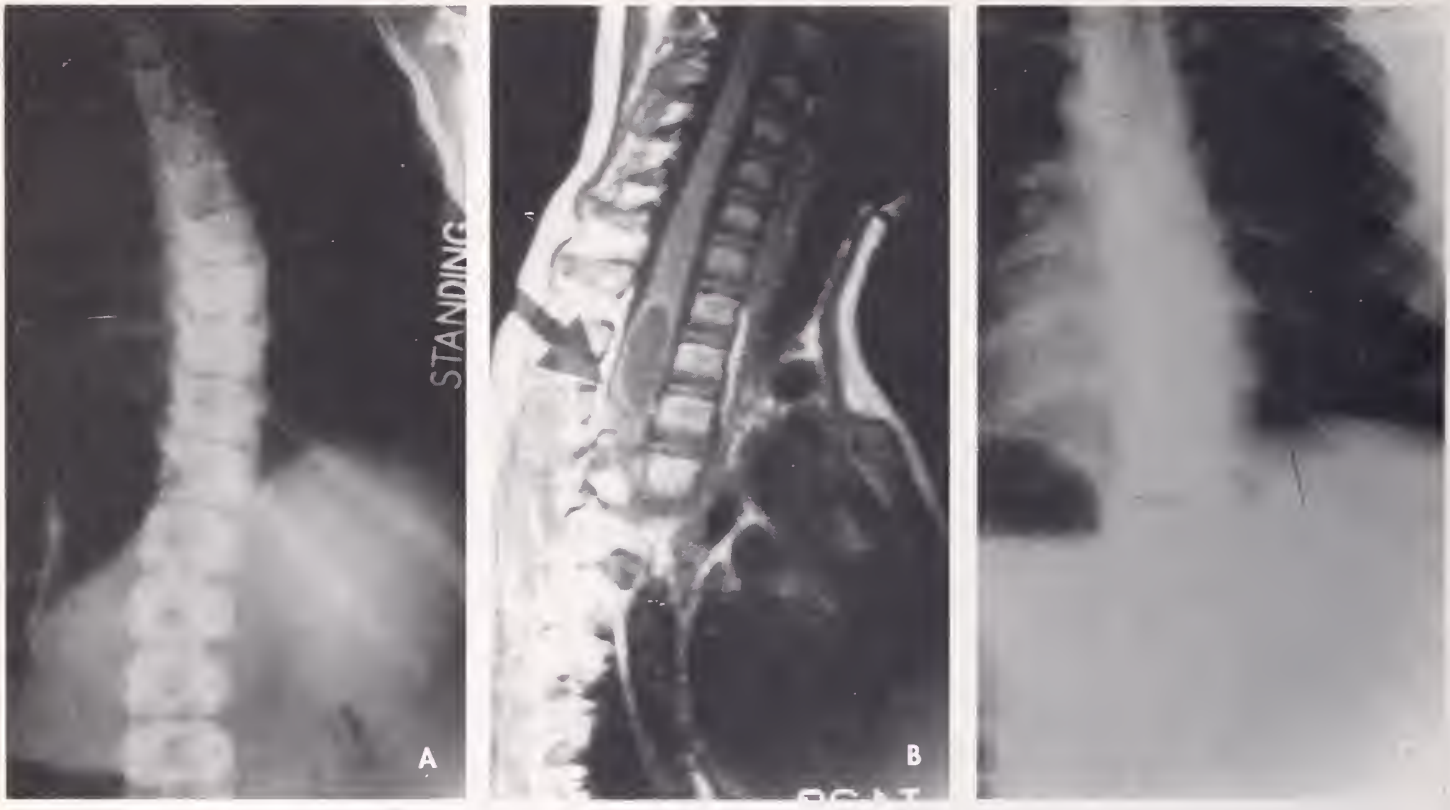


Fig 1 — (A) Nine-year-old female presenting with 27 degree right thoracic scoliosis; (B) MRI with intramedullary dilatation within the thoracic cord; (C) Decreased scoliosis following astrocytoma resection.

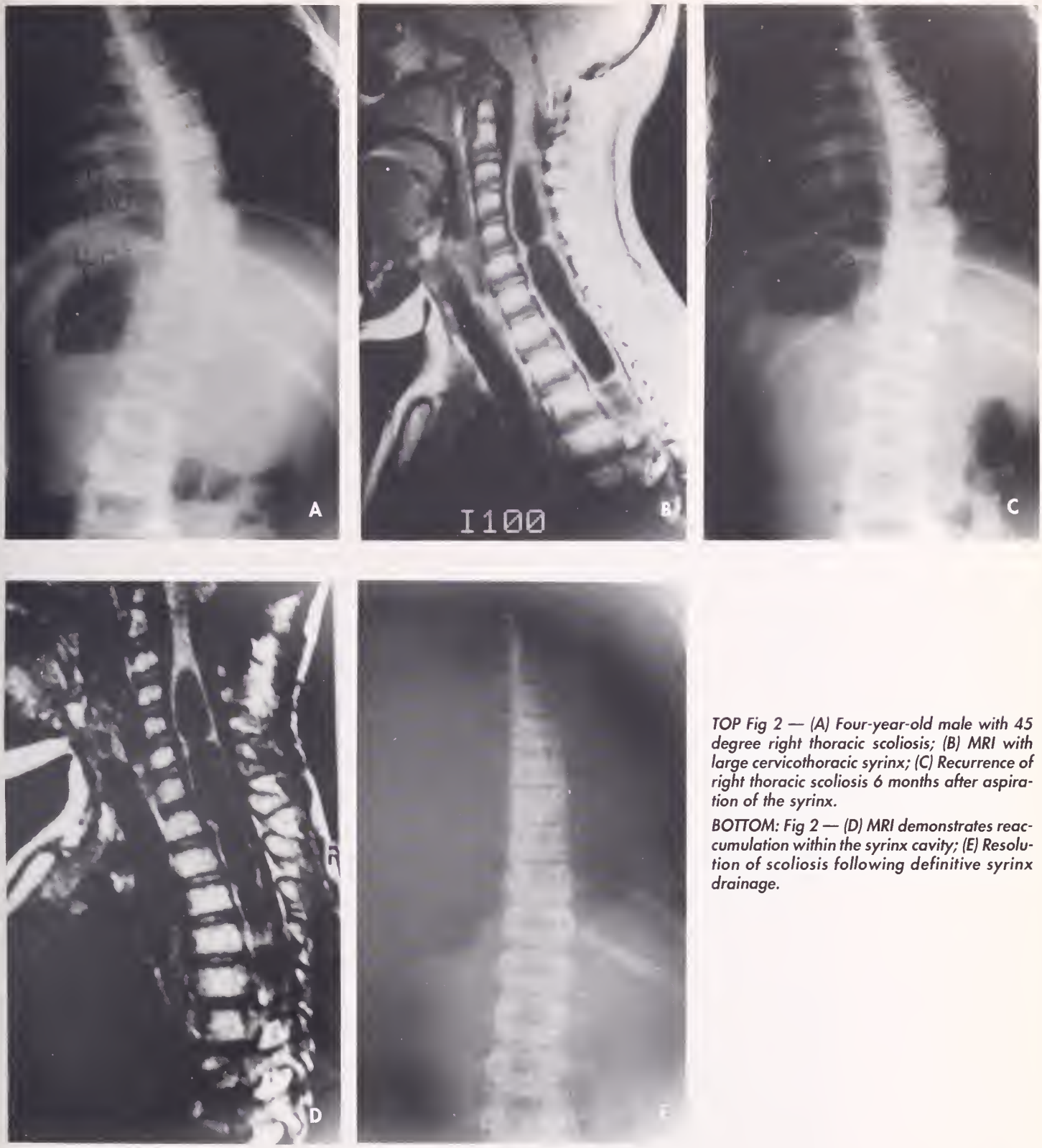
sis. Second, the patient had what appeared to be a very rapid progression of her curvature despite the absence of a concurrent growth spurt. On the basis of these abnormalities, a further work-up consisting of bone scan and MRI scan was recommended. Although the bone scan was unremarkable, the MRI scan revealed an intramedullary dilatation of the entire thoracic cord, consistent with either syrinx or intramedullary neoplasm (Fig 1B). At this point, neurosurgical evaluation was obtained. Subsequently evaluation with gadolinium enhanced MRI scan revealed a focally enhancing intramedullary lesion at the T5-T6 level. Based on the association of intramedullary neoplasm and syrinx cavity, astrocytoma was suspected.

On the basis of these studies, surgical excision of the lesion was performed. Complete excision was obtained using adjunctive somatosensory evoked potential and motor evoked potential monitoring. The patient's post-operative course was uncomplicated. Subsequent radiographic follow-up revealed a progressive decrease in her scoliosis over the next year. (Fig 1C)

Case 2 — A 4-year-old white male was referred for evaluation of scoliosis noted on routine examination. The patient was the product of a full term pregnancy and had a normal delivery with the exception of being one of a set of twins. The parents reported normal growth and development. They did feel that his curvature had worsened during the 8 weeks between the time of diagnosis and tertiary evaluation. There was no history of neurologic abnormality.

On physical examination the patient stood listing slightly to the right. He had a level pelvis and equal leg lengths. There was a notable right thoracic scoliosis on forward bending with persistence of his list. Neurologic examination was remarkable only for increased tightness in the hamstring on the right. Plain radiographs revealed a 45 degree right thoracic scoliosis. (Fig 2A)

Despite the presence of a curve pattern con-



TOP Fig 2 — (A) Four-year-old male with 45 degree right thoracic scoliosis; (B) MRI with large cervicothoracic syrinx; (C) Recurrence of right thoracic scoliosis 6 months after aspiration of the syrinx.

BOTTOM: Fig 2 — (D) MRI demonstrates reaccumulation within the syrinx cavity; (E) Resolution of scoliosis following definitive syrinx drainage.

sistent with juvenile idiopathic scoliosis, the patient had findings of asymmetry and hamstring tightness which raised the suspicion of an alternative etiology. Based on these findings, MRI examination and neurological consultation were recommended. The MRI revealed a Chiari I malformation and a large syrinx at the level of the cervical spine (Fig 2B). Treatment consisted of foramen magnum decompression and drainage of the syrinx by needle aspiration.

Three months postoperatively, the right thoracic curvature had decreased from 45 to 22 degrees. At 6 months postoperatively, neurologic examination remained normal; however, the curvature had increased to 28 degrees on plain radiograph (Fig 2C). At this point, MRI scan revealed a recurrence of the syrinx (Fig 2D), which was treated with placement of a syringo-subarachnoid shunt. Subsequent follow-up evaluations, most recently at 4 years postoperatively, reveal a resolution of the spine deformity (Fig 2E).

Discussion

Neurogenic scoliosis, although relatively uncommon, is important as a marker for the underlying etiologic neural axis defect. Scoliosis has been reported as the presenting feature in patients with intramedullary spinal cord tumors[1,2] and syringomyelia.[3,4,5] In this series, scoliosis was the initial finding in all cases. Identification of those scoliosis patients with an undiagnosed spinal cord abnormality relies upon a thorough history and physical examination, which will then suggest the appropriate radiologic evaluation.

Adolescent idiopathic scoliosis is most common in girls. It should present painlessly, and in conjunction with the patient's adolescent growth spurt. No history of neurologic deficit or change in neurologic function is anticipated. In contrast, complaints of pain, neurologic changes, or excessively rapid curve progression are all suggestive of an alternative etiology. Although pain is not a feature of idiopathic scoliosis, adolescents concerned with their deformity may overemphasize intermittent activity related backache. However, a level of pain which restricts activity is more worrisome, and underlying pathology must be excluded. Night pain has been associated with the presence of an underlying tumor. A herniated disc, although unusual in children, can occur. Neurologic deficit may present as difficulty with balance, change in gait, numbness, tingling, or deterioration in bowel or bladder function.

Juvenile idiopathic scoliosis is defined as a curvature which develops after age 3 but before the onset of the adolescent growth spurt.[6] While scoliosis in a younger patient might be idiopathic, the concern for an underlying primary etiology is certainly greater in this group of patients. Because of the increased risk of intraspinal pathology, a recent study recommends routine use of MRI in children less than 11 years of age who present with scoliosis.[3] Others have recommended further investigation only if additional findings point toward an atypical presentation.[7]

Physical examination may also provide either obvious or subtle indications of an underlying neurogenic etiology. Careful examination of the back for dermatologic abnormalities such as a hairy patch, or abnormal neuroectodermal remnants such as a sinus tract, can be critical. Postural imbalance, which may produce either a significant list, or asymmetry on forward bending, is important. Pain elicited on flexion of the neck in combination with straight leg raising may be indicative of a tethered spinal cord (L'Hermitte's sign). The neurologic examination must be comprehensive and attentive to subtle reflex or sensory changes, spasticity, or clonus. In particular the loss of a cutaneoabdominal reflex has been suggested as a frequently overlooked clinical finding in spinal cord lesions.

If any suspicion of a neural axis abnormality exists, especially in younger children, further investigation is warranted. The advent of MRI technology has led to significant improvement in the detection and diagnosis of spinal cord abnormalities. While myelography and post-myelographic CT scan has been the standard of care in the past,[8] MRI scan is rapidly replacing the more invasive myelogram as the evaluation of choice for neural axis defects. Although the MRI is generally unaffected by small curvatures, larger curvatures can present a technical problem in that the curve may take the spinal canal out of the plane of the MRI scan. Nonetheless, the noninvasive nature of the test, and the absence of ionizing radiation such as would be required with a CT scan, are very advantageous factors.

Children with scoliosis are routinely evaluated and followed with plain radiographs of the spine. the radiographic abnormality which most often suggests a neurogenic etiology is the presence of an atypcial curve pattern. Idiopathic scoliosis tends to occur in one of five standard patterns[9] (Table). The most common pattern is right thoracic scoliosis with the apex in the T7, T8 re-

gion. Left thoracic curves are rare, constituting only 1.5% of actual idiopathic curves in one series.[10] Isolated cervicothoracic curves are also strongly associated with a nonidiopathic etiology. Other significant radiographic findings include spina bifida occulta which may be associated with a tethered spinal cord, and widening of the diameter of the cervical canal which may be indicative of syringomyelia,[4] or intramedullary tumor.[2]

Several recent studies have investigated the efficacy of MRI in the evaluation of scoliosis.[3, 11, 12, 13] Lewonowski et al performed MRI scans on all children younger than age 11 years presenting with a presumed idiopathic scoliosis. In a series of 26 patients, underlying neural axis defects were identified in five patients (19.2%). Neuropathology included a Chiari I malformation in two patients, syringomyelia in one patient, intramedullary tumor in one patient, and a tethered spinal cord secondary to lipoma in one patient. Only two of the five patients had left thoracic curvatures. The authors conclude that patients with progressive scoliosis associated with any unusual features, including age less than 11 years, should be evaluated by MRI scan. They base these recommendations in part on a report of significant neurologic injury following surgical correction of scoliosis with an undetected underlying syrinx.[4, 5] They also site the benefit of early detection in cases of intramedullary spinal cord tumor.[2] While these risks cannot be denied, the frequency with which spinal cord abnormalities are identified in Lewonowski's series indirectly implies a low incidence of complications with treatment. If spinal cord abnormalities were rarely identified in the past, and the true incidence approaches 20%, then certainly many children with a neurogenic scoliosis have undergone surgical correction without detectable sequelae, at least in the short term.

A second study reviewed MRI scans in adolescents and juveniles believed to have idiopathic scoliosis.[14] Forty-nine adolescents were evaluated for indications which included pain, atypical curve pattern, and neurologic complaints. Eleven of the 49 patients (15.4%) had abnormal studies, including Chiari malformation in four cases and syringomyelia in five cases. In a second group of 17 infants and juveniles thought to have idiopathic deformities, MRI abnormalities were noted in eight (47%) cases. The authors recommended a large prospective study to define the prevalence of spinal cord anomalies in these groups.

Table 1. King's Classification of Idiopathic Scoliosis

Type	Description
I	Primary Lumbar/Compensatory Thoracic
II	Primary Thoracic/Compensatory Lumbar
III	Right Thoracic ONLY
IV	Long Thoracolumbar
V	Right Thoracic/High Left Thoracic

Treatment of neurogenic scoliosis is based primarily on treatment of the underlying neural axis abnormality. This may involve posterior fossa decompression in the case of an Arnold-Chiari malformation, aspiration or shunt placement for a syrinx, release of a tethered spinal cord, or resection for an intramedullary tumor. In many cases, treatment of the spinal cord abnormality will result in subsequent diminution of the spinal deformity. In other instances, the scoliosis may have developed sufficient structural characteristics, over time, that the deformity continues to progress despite neurosurgical intervention. In such cases, subsequent instrumentation and spinal fusion may be necessary.

In a study of scoliosis secondary to syringomyelia,[7] 80% of the 25 patients were less than age 11, and only 10 patients had abnormal neurologic findings. In eight cases, treatment of the curvature by bracing was attempted. Although the curves responded initially to brace treatment, correction was not maintained after removal of the brace. In 16 patients, neurosurgical decompression of the syrinx was undertaken, and in general improvement in the curvature was noted. Nonetheless, 11 patients eventually progressed to the degree that spinal fusion was required.

In a series of patients with scoliosis secondary to tethered cord and myelomeningocele, McLone found that curves greater than 60 degrees tend to progress despite release of the tethered cord.[15] While these findings may be influenced by the presence of the myelomeningocele, the subsequent progression of larger curves was also seen in our series. Two of the 14 curves in our series have required fusion thus far, although not all patients have been followed to skeletal maturity. In both cases, one secondary to syringomyelia and one secondary to tethered spinal cord, the initial scoliosis was greater than 60 degrees.

If extensive laminectomy is required, such as for tumor resection, concomitant fusion may

be necessary to avoid a severe kyphosis postoperatively.[2,5] In most cases, however, appropriate neurosurgical treatment that does not destabilize the spine by excessive bony resection will not lead to or promote progression of the deformity. Nonetheless, careful observation until skeletal maturity remains essential. As with idiopathic scoliosis, the adolescent growth spurt is a period of increased risk for curve progression despite correction of the underlying neural abnormality.

In summary, spinal cord abnormalities are an unusual but important cause of scoliosis in children. Diagnosis depends upon thorough history and physical examination with subsequent MRI screening when suspicion is aroused. With early diagnosis and treatment of the underlying abnormality, the scoliosis will frequently resolve spontaneously; however, follow-up must be continued until skeletal maturity as subsequent progression of deformity may occur. Finally, as other authors have noted[1,5] these patients will benefit from combined orthopaedic and neurosurgical management to facilitate efficient and efficacious treatment.

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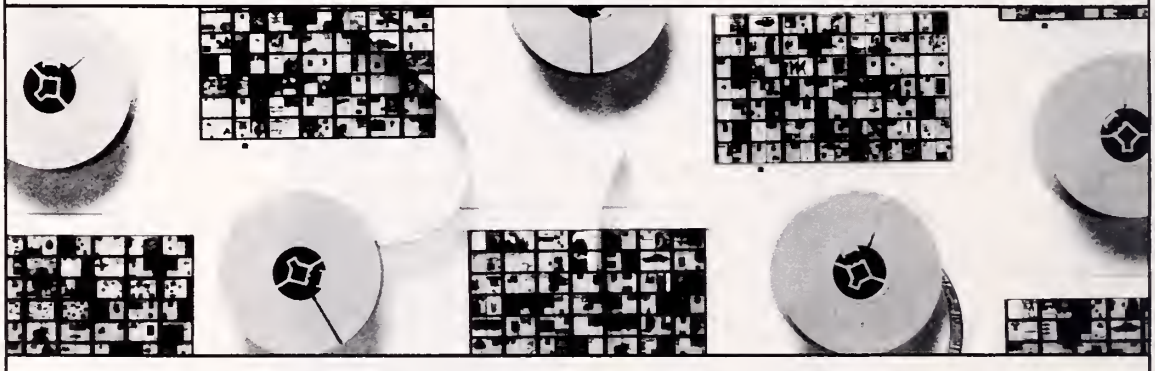
6-10 — Southeastern Surgical Congress; Buena Vista Palace, Lake Buena Vista, Florida. Contact: The Congress Office, Suite 410N, 1776 Peachtree St, Atlanta, GA 30309; 404/607-8958.

27-March 4 — Mayfield Winter Neurosurgical Sympasium; Snowmass, CO. Sponsored by Mayfield Neurological Institute. Contact: Sheila Stuckey, Meeting Coordinator, Mayfield Neurological Institute, 506 Oak St, Cincinnati, OH 45219; 513/569-5251, FAX 513/569-5365

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Manage to Care

Managed care is here to stay. It is not a mere possibility, pending the outcome of the Clinton Health Care Proposal. In California, the *reality* for many ophthalmologists TODAY is that average reimbursement per patient per month for Medicare patients or "senior" is 8.6 dollars. Average reimbursement of "commercial" patients is 12 cents per patient per month. A volume of 2,500 "seniors" and 20,000 "commercials" is suggested for economic viability. But suggestions are rarely made for maintaining viability of *providing* care. The real challenge in managed care will be managing to provide needed care when economics and patient volume create obstacles to caregiving.

Listen to the new language of managed care. There are three goals: universal access, low cost, and "APPROPRIATE" quality. Two of these goals are absolute: cost and access. The expendable parameter to managed care architects is quality. The new language of managed care never refers to the practice of medicine. It suggests that care is a static object that could be wrapped in a box and delivered, yet we all know it is an ongoing process of interaction between sometimes many physicians and individual patients, as well as their families.

It will fall to physicians to ensure that patients still receive *the care required,* which means ensuring that the systems structured will permit this. There is universal acknowledgement that the best medical care available in the world today is in the United States. We must insist on structure care systems which will permit this to continue.

This means, we must be willing to take the initiative to form networks in anticipation of patient needs which maintain quality of care. In mega insurance groups, the goal is to manage *us.* We must be the patient's advocate in assessing details of managed care programs brought to us. Reimbursement is based on *VOLUME* of patients, not level of difficulty, sophistication of technology, risk of procedure or even volume of procedures. Some physicians will be tempted to take on an unmanageable volume just to permit keeping the lights on in the office.

If paraprofessionals become the gatekeepers, we must remain the patient guardians. Our high quality of care has come to be taken for granted by many. This translates into the belief that anyone can do what physicians in the United States do today: nurses, paraprofessionals, or even clerks with detailed books of symptoms and appropriate actions. It has been said in defense of nurse practitioners practicing medicine independently that "they can do 80% of what a physician can do." For the sake of argument, suppose that were true — Who wishes their child's diagnosis to be 80% correct? Who finds it acceptable to be one of the 20% who fall outside the margins? Physicians, already, are not without error, but are held to a standard of 100% accuracy and lack of maloccurrence. Suddenly, it's "acceptable" to miss 20% of the time, since it costs less? And what is the margin of variation between an excellent diagnostician and a very good one? . . . Far less than 20%.

Finally, there is no doubt that the ability to truly care for individuals will be better maintained if the private sector determines the complexion of these programs. As great a service as Medicare and the VA systems have been to many people, any of us intimately familiar with the workings of these systems knows the heavy price the quality of medicine in the United States would pay if entirely turned over to the federal government.

Not only do we need to maintain the quality, innovation, and sensitivity in the practice of medicine, we also need to maintain these qualities in the education of our future physicians. This is also threatened by federal intervention, as the federal government would hope not only to assume the training of physicians, but also to dictate the specialties into which physicians could go. This is an intrusion unheard of before in America.

The challenge before us is to manage to care in the conscientious, ever inquisitive, probing and ethical way that is the cornerstone of the highest quality medical system in the world today.

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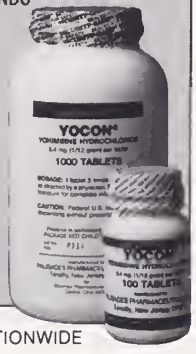
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Health Care—the Political Issue of the 90s



Gloria J. Griffin

"Whenever the people are well informed, they can be trusted with their government: yet when things get so far wrong as to attract their notice they may be relied upon to set things right."

—Thomas Jefferson

Health Systems Reform has become a major priority in the US and Kentucky General Session. At the AMA Interim meeting, I had the opportunity to observe physicians from across the nation as they spoke about Health Systems Reform and how it will affect every citizen in this country. It's apparent that what physicians and patients really don't want is more rhetoric, but clear evidence that their concerns will be addressed; that the quality of care will at least be as good as it is today; that patients will still have the freedom to choose their own doctor and the facilities that give them care.

The mission of the Kentucky Medical Association Alliance is to work in coalition with the Kentucky Medical Association to promote quality health care and sound legislation.

As physicians' spouses, we are all emissaries for the medical profession. As members of the medical community, our responsibility is to be as educated and informed about these political issues as our spouses. We must continue to be effective communicators with members in the state and national legislature about this impending Health System Reform legislation. It is going to adversely affect in a dramatic way the ability of our spouses to deliver quality medical care in Kentucky.

Physicians in Kentucky will be requiring our visible support and involvement as a united front with active membership and involvement in the Kentucky Medical Association Alliance. We are the care givers to our family of medicine; we should all be proud of the opportunity to serve the profession of medicine, as we work side by side with our county, state, and national medical associations in an all-out legislative grass roots effort this year.

There are several scheduled meetings in late January and February specifically for physician spouses. Additional meeting information will be in the weekly Health System Reform mailed to all Kentucky physicians. I expect to see you there.

- January 20 —
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  Contact KMA 502/426-6200
- January 27 —
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  9:30 am-2:00 pm — Lexington
  Contact Joan Slatterly-Burke
  606/273-2057
  KMA Phone Bank Chairman and Fayette County Auxiliary member
- February 16 — KMA Alliance Legislative Day at the Capitol
  10:30 am-2:00 pm — Frankfort
  Contact Dr Nancy Swikert
  606/525-6247

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New York, NY 10020

This book, about to be published, times itself for the public's insatiable consumption of the macabre. Recent headlines and bylines graphically document the increase in crime, particularly violent crime. Quieter words such as "drug related" or "family violence" disguise some more demonic crime, switching the source to a less threatening, more distant perpetrator. Nevertheless, sometimes none of us understand why something happened, how could this act have been committed, and who could be held responsible? Dr Hare, the scientist, and Dr Hare, the psychologist, merge their perspectives in this book about some of these people. He quickly abandons Freudian psychodynamics for the data studded psychophysiological approach. Behavior science and experimental psychology are more malleable and are his tools to bring some understanding to what sometimes seems unfathomable.

Dr Hare's audiences are the public, the legal workers, and the health care givers. Such a fuzzy focus weakens the scientific value of this book, but greatly enhances its readability and interest. His numerous examples from a tremendous experience pique the curiosity of the reader, to the point that education from the material is readily obtained. White collar and blue collar, blue blood and red blood — psychopaths come in all forms and in both sexes. Chapters such as "The Profile: Lifestyle," "Crime: The Logical Choice," and "Words from an Overcoat Pocket" divide the subject into palatable portions. The last chapters about what can be done and surviving the psychopath are certainly not uplifting. Society's effort to change, treat, socialize, contain or anything short of capitally punish the psychopath is arguably necessary, but rarely successful. Protect yourself, Dr Hare warns solemnly, and don't tread on them. A psychopath's dearth of morality, principles, cares, etc, defies any mutual beneficial relationship. Their polar view of life, that their life and rewards are tantamount, make rehabilitation a long shot. Remember that not just murder, but repetitive theft, lying, violence, and other misdeeds are all part of the psychopath's repertoire.

That this book will make a difference when you read it, I have no doubt. It's worth the paper and print, the time you spend, and the cost. Cheap prophylaxis, if you can avoid being hurt by the psychopath, and this book arms you with some protective mechanisms.

Stephen Z. Smith, MD
Book Review Editor

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Statewide Cato Society Meeting

This, the fourth annual statewide Cato Society meeting was held during the Annual Meeting of the Kentucky Medical Association at the Hyatt Regency Hotel in Louisville. Two previous ones were held in Louisville (September 1990, 1992) hosted by the Jefferson County Medical Society (JCMS) and one held in Lexington (October 1991) hosted by the Fayette County Medical Society.

The Cato Society is a unique society whose members are retired physicians or those over 65 years of age. The Society has no officers, no dues, no political objectives, and but a few small service functions. Its main purpose is to provide a forum for fellowship. As physicians, during years of practice, we have had opportunities to share the fellowship of colleagues in hospital staff lounges, or suites, Medical Society and hospital staff meetings. When retirement age overtakes us many miss these frequent interchanges with colleagues. The Senior Physicians Committee of JCMS addressed this deficiency with this informal Society. It seems to have supplied a need and an opportunity to share an hour with old friends. JCMS has also conducted nine meetings of the local Cato Society at which 50-80 have attended. At local meetings we have invited wives to join us. We meet twice a year, in Spring (April) and Fall (October), at which a light noon meal is served. Most times a 20-30 minute program is presented. The subjects addressed are not necessarily medical, but some have been tangentially related to our profession and adjudged of current interest.

These activities are financed by subscription. The staff assistance, stationery and postage have been generously underwritten by the JCMS.

This year's statewide meeting was organized by Chairman George W. "Bill" Pedigo, MD, Louisville, with the administrative assistance and staff support from JCMS and KMA. As has become customary, we have a continental breakfast and convene at 9:30 AM in the hotel where the KMA has its convention headquarters. Our continental breakfast was presented in the Keeneland Room of the Hyatt as our members began to assemble. This year's attendance reached 75, 23 of whom were from other counties than Jefferson. Fourteen counties were represented and two members attended from retirement in Florida. We had six women physicians and two husband and wife physician pairs.

The chairman of the JCMS Senior Physicians Committee extended a welcome to all members present and later, when reminded by friends, gave a brief account of the activities of the Cato Society.

Many have asked: Why Cato? Cato who? This Cato Society was named for Cato, the Elder of ancient Rome who lived to the age of 85 years and served his fellow citizens as soldier, jurist, farmer, and author for his entire lifetime. Once a year we have honored those colleagues who have attained the age of 85 years, and we recognize their lifetime of service to their family, patients, and colleagues with a "Scroll Award."

Since some retired colleagues in KMA have asked not to receive mailings from Headquarters, we have experienced difficulty in addressing some 1,000 physicians who are retired from practice in Kentucky. If you would like to join the Cato Society or know of an eligible colleague who would want to receive our mailings concerning meetings focused on fellowship (we do not sell this list to anyone), please call Mrs Chandra M. Abrams at the JCMS 502/589-2001 for information and to have your names added to our list.

That you may see who attended this year's meeting, we have listed their names, and several photographs of activities at this Fourth Annual Meeting have been appended.

Eugene H. Conner, MD
Louisville, KY



Earl P. Oliver, MD (L), Scottsville, Allen Co, chats with an old friend and once a fellow rural practitioner, Robert S. Dyer, MD, Louisville, Jefferson Co.

Alfano, Frank, MD
Bennett, W. Neal, "Bud," MD
Berg, Harold, MD
Bloch, Austin, MD
Bradley, Herbert, MD
Cheng, Samuel, MD
Clark, Orville, MD
Claugus, Clarence, MD
Clay, Herbert, MD
Coe, Walter, MD
Conner, Eugene, MD
Davis, James, MD
DeMunbrun, Donne, MD
DeMunbrun, T. W., MD
Denham, Ralph, MD
Dennis, Elbert, MD
Durham, William, MD
Dyer, Robert, MD
Eskind, Harold, MD
Foshee, Clyde, MD
Fowler, Merle W., Jr., MD — Paducah
Gaines, Frank, MD
Gardner, Hoyt, MD
Gettelfinger, Wilfrid, MD
Giesel, Lewis, MD
Griffin, David, MD
Grumbles, Cecil, MD
Haeberle, C. l., MD — Russell
Hamilton, Wm. Bruce, MD
Hawn, William, MD
Hoffman, Charles, MD
Hopkins, William, MD — Anchorage
Jones, Conrad, MD — Murray
Juers, Arthur, MD
Kimsey, Letitia, MD
Lewis, Blaine, MD
Ligon, Champ, MD — Lexington
Lowry, Conie, MD — Murray
Marshall, Tom, MD
McClendon, Robert, MD
McManus, Wm., MD — Owensboro
Miller, T. R., MD — Lexington
Nash, William, MD — Naples, FL
Norvell, Wyatt, MD — New Castle
Oliver, Earl, MD — Scottsville
Orrahood, David, MD — Owensboro
Perlstein, Irving, MD
Petry, John, MD
Phillips, R. J., MD — Gilbertsville
Popham, Bernard, MD — Brandenburg
Reid, Ben, Sr., MD
Robie, Carroll, MD
Roser, Charles, MD
Roser, Katie
Ryan, John, MD
Ryan, Ruth
Salter, James, MD — Richmond
Schoo, Bernard, MD
Seeley, E. C., MD — Lexington
Smith, John, MD
Smith, Orson, MD



L to R: David Orrahood, MD, and William McManus, MD, Owensboro; R. J. Phillips, MD, Gilbertsville, Marshall Co; Elliott Stevens, MD, Owensboro.



L to R: Wilfred C. Gettlefinger, MD, Louisville, Jefferson Co; Donald Stevens, MD, Alexandria, Campbell Co; Daniel A. Tobin, MD, and Arthur L. Juers, MD, Louisville, Jefferson Co; in immediate foreground Herbert L. Clay, Jr, MD, Louisville, Jefferson Co.



L to R: Irving Perlstein, MD, Louisville, Jefferson Co; Blaine Lewis, MD, Louisville; William N. Nash, MD, Naples, FL; W. Neale Bennett, MD, Louisville.

Sonne, John, MD — Bardstown
Stevens, Donald, MD — Alexandria
Stevens, Elliott, MD — Owensboro
Stewart, Martha, MD
Stinnette, Kenneth, MD — Bardstown
Tobin, Daniel, MD
Townsend, H. L., MD
Twyman, Will, MD
Weakley, Lolita, MD
Weakley, Sam, MD
Wing, Morgan, MD — Palm Bay, FL
Wiss, Mary, MD — Pikeville
Abrams, Chandra — JCMS
Kruer, Chris — JCMS

PEOPLE

Morehead State University was host in November when the accomplishments of **Claire Louise Caudill, MD,** and her nurse associate Susie Halbleib were celebrated in an original one-woman show, "Me 'n Susie," written and performed by Dr Shirley Gish, MSU associate professor of speech, and directed by Dr Travis Lockhart, MSU associate professor of theatre.

Following graduation from the University of Louisville School of Medicine in 1946, "Dr Louise," as she is affectionately known, began practicing medicine in Eastern Kentucky at a time when there were few female physicians even on the national scene. Dr Caudill, who is 81 years young, joined KMA in 1948, the year she returned to her hometown of Morehead to set up practice. She was accompanied by Susie Halbleib, and working side by side over the years, these two remarkable women have dramatically impacted the course of medical treatment in the Eastern Kentucky region and have demonstrated an immeasurable commitment to the people of this area.

Russell L. Travis, MD, was the 1993 recipient of the Distinguished Service Award of the Congress of Neurological Surgeons. In its announcement of the award, the Congress included the following comments:

"Russell Travis was a unanimous choice of the Selection Committee this year because of his continued and truly exceptional contribution to organized neurosurgery. Dr Travis has been instrumental in providing education and leadership to both the officers of the Congress as well as its membership in the important area of health care reform. Dr Travis has always been a strong advocate for the patients receiving neurosurgical treatment and has provided an evenhanded view of the legislative process involved in improving the delivery of neurosurgical care. Dr Travis has sat on the Executive Committee of the Congress for several years and provided the viewpoint of a practicing neurosurgeon in the important arena of health care delivery changes. In addition to these many contributions, he has also provided sound clinical experience and advice in advising clinical educational programs for the Congress."

Edward L. W. Scofield, MD, JCMS President, was honored with the University of Louisville College of Arts and Sciences Alumni Service Award, and **William P. VonderHaar, MD,** KMA Secretary-Treasurer, was recipient of the U of L School of Medicine Alumni Service Award, which were presented during the U of L/Navy game on October 23.

Clovis A. Crabtree, MD, Louisville, is serving with the Southern Medical Association (SMA) as State Councilor for Kentucky. He joined 16 other state representatives and officers as they convened in business meetings of the Association at the SMA's 87th Annual Scientific Assembly held in New Orleans.

J. Thomas Badgett, MD, PhD, associate professor of pediatrics and director of Kosair Ambulatory Pediatrics, has received a grant in conjunction with Kosair Children's Hospital to develop a "smart card," to be used for tracking children's immunization records. The card works like a magnetic bank card with the computer chip power to store several pages of data.

At the 1993 AMA Annual Meeting, University of Kentucky College of Medicine Dean **Emery Wilson, MD,** was elected Chairman-Elect of the Governing Council of the AMA Section of Medical Schools. Dr Wilson will assume the office as Chairman of the Section at the 1994 AMA Annual Meeting.

Nigel Harris, MD, U of L department of medicine, was one of six researchers to receive the 1993 League Against Rheumatism Rheumatology Prize for advances in the field of rheumatology in the past decade.

Nettie Graham King, MD, clinical associate professor of radiology at the University of Louisville, will be among 10 distinguished graduates to be honored this spring as 1994 Alumni Fellows. Honorees were nominated by academic units based on outstanding contributions in their respective fields.

David R. Cundiff, MD, MPH, director of health services for the Jefferson County Department of Health, was recently elected to a 2-year term on the Board of Directors of the National Association of County Health Officials. He also serves as a member of the Data Systems Oversight and Development Work Group of the Joint Council of Official Public Health Organizations.

Michael C. Cronen, DO, has been appointed to the Board of Directors of the Kentucky Osteopathic Medical Association for a 3-year tenure. The KOMA serves more than 100 osteopaths throughout the state. Dr Cronen also serves on the Board Certification Committee of the American Association of Osteopathic Specialists.

Allan H. Rees, MD, University of Louisville pediatric cardiology, was chosen by U of L pediatric residents to receive the 1993 Outstanding Clinical Professor Award.

Francisco Elbl, MD, and **Allan Rees, MD,** U of L pediatric cardiology, and **Erle Harris Austin, III,** U of L

pediatric cardiovascular surgery, received a Humanitarian Award from Louisville Mayor Jerry Abramson for their care of Latin American children with congenital heart defects.

Baby Jose, University of Louisville department of radiation oncology, recently received a fellowship degree from the American College of Radiology. He was the only recipient from the state of Kentucky.

UPDATES

TV Violence Traumatizes Children, Expert Says

Television violence can traumatize children, and the worst of the TV shows may be Saturday morning cartoons, says a University of Louisville psychiatrist.

Mohammad Shafii, MD, says television has addictive qualities that cause adults and children to react in different ways. Watching a murder mystery may make the viewer tense; programs demonstrating lack of respect for another human being may provoke anger; or an action adventure may cause aggressive behavior.

Dr Shafii says cartoons are particularly harmful because many children watch them alone while their parents sleep. Parents should watch the cartoons with their children to help the youngsters distinguish fantasy from reality, he says. He also advises parents to promote reading, outdoor sports, and family conversations as alternatives to TV viewing.

Continuing Medical Education Regulation

On October 13, 1993, the regulation relating to mandatory continuing medical education for physicians became effective. The regulation is similar to the one published in the July "Communicator" except for minor legal clarifications in wording which did not alter the intent of the regulation. The regulation specifies that beginning January 1, 1994, physicians will be required to complete a minimum of 60 hours of CME before January 1, 1997. Please note that any courses taken before January 1, 1994, do not count toward the regulation.

The KMA has had numerous questions regarding the specific requirement in the regulation for the two (2) hour course on HIV/AIDS. The regulation specifies that the course be "approved by the Cabinet for Human Resources." Numerous courses approved by the Cabinet for Human Resources are currently being offered around the state. For a list of the availability of Cabinet for Human Resources approved education courses on HIV/AIDS in Kentucky, contact the Kentucky AIDS Education Program, Department for Health Services, 1st Floor West, 275 East Main Street, Frankfort, KY 40621-0001, or call 502/564-6539. Please note that any HIV/AIDS course taken before January 1, 1994, does not fulfill the regulation.

The Kentucky Medical Association is in the process of planning a two (2) hour HIV/AIDS course to be presented at the 1994 KMA Annual Meeting. The course is only in the planning stages and we will provide more information at a later time when the course is finalized.

If you have questions about the CME regulation, please contact the Kentucky Board of Medical Licensure at 502/429-8046.

Physician Self-Referrals

On August 10, 1993, President Clinton signed the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66). In addition to trimming Medicare and Medicaid spending over the next 5 years, P.L. 103-66 also extends the ban on physician self-referrals beyond clinical laboratory services to 11 designated types of health care services. This prohibition extends to Medicaid as well as Medicare. The expanded prohibition will apply to the following "designated health services":

- parenteral and enteral nutrients, equipment, and supplies
- prosthetics, orthotics, and prosthetic devices
- home health services
- outpatient prescription drugs
- inpatient and outpatient hospital services
- clinical laboratory services
- physical therapy services
- occupational therapy services
- radiology or other diagnostic tests
- radiation therapy services
- durable medical equipment

The amendments extending the physician self-referrals prohibition becomes effective January 1, 1995.

Economic Entity and Public Education Committees Appointed

The 1993 KMA House of Delegates approved the establishment of two new committees for the Association. Resolution B set up a study group to look into the feasibility of establishing a physician-owned and directed economic entity which allows all KMA members the opportunity to participate in delivery and payments systems evolving from state and national health system reform measures. The Economic Entity Committee held its first meeting on December 15.

Resolution H established the Public Education Committee which has been appointed and held its first meeting on November 23. The Committee will develop and initiate a permanent and ongoing public education campaign to bring to the attention of the people of Kentucky the positive aspects of the physicians of Kentucky.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Bath

Mark E. Bailey, MD — FP
PO Box 578, Owingsville 40360
1991, U of Kentucky

Daviess

James A. Coomes, MD — IM
4111 Brookhill Dr, Owensboro 42303
1989, U of Louisville

Christopher C. Glaser, MD — S
2816 Veach Rd Bldg 5, Owensboro 42303
1988, U of Louisville

Fayette

John M. Harris, MD — S
1401 Harrodsburg Rd B355, Lexington 40504
1988, U of Hawaii

Richard C. Haydon, III, MD — OTO
800 Rose St C236, Lexington 40536
1978, U of Virginia

Charles G. Ison, MD — PD
2620 Wilhite Dr, Lexington 40503
1990, U of Kentucky

John R. Jenkins, MD — AN
3320 Tates Creek Rd #204, Lexington 40502
1989, U of Virginia

Darren L. Johnson, MD — ORS
UKMC — Orthopaedics, Lexington 40536
1987, UCLA

Douglas J. Nesbitt, MD — EM
3650 Boston Rd #T, Lexington 40514
1974, U of Ottawa

Mark W. Richardson, MD — AN
1800 S Limestone #400, Lexington 40503
1989, Texas A & M

Joseph Valentino, MD — OTO
UKMC — ENT C236, Lexington 40536
1987, Robert Wood Johnson Med School

Martin V. Vogt, MD — AN
1800 S Limestone, Lexington 40503
1986, U of Kentucky

Allen B. Wilcox, Jr, MD — TS
168 Burt Rd, Lexington 40503
1986, U of Tennessee

Floyd

Zakiuddin Ahmed, MD — IM
PO Box 305, Wheelwright 41669
1981, Dacca Medical Col

Greenup

Susan M. Lichtenberger, MD — PD
900 St Christopher Bldg 4 #101, Ashland 41101
1987, Wright State

Hardin

Daniel D. Kuo, MD — AN
73 Whispering Pine Way E, Elizabethtown 42701
1987, Loyola

Harlan

Arun Lall, MD — AN
Harlan ARH, Harlan 40831
1979, University of Med Sci, New Delhi

Jefferson

Stanley R. Frager, PhD
3906 Dupont Sq, Louisville 40207

Jeffrey H. Frank, MD — N
6400 Dutchman's Pky #315, Louisville 40205
1981, U of Kentucky

Gary J. Harris, MD — S
8909 Raintree Dr, Louisville 40220
1983, U of Texas, San Antonio

Thomas J. Schreiner, MD — PD
4404 Churchman Ave #404, Louisville 40215
1985, U of Louisville

Philip D. Shrake, MD — R
801 Barret Ave #106, Louisville 40204
1989, Indiana U

Marcus F. Stoddard, MD — C
1002 Springside Way, Louisville 40223
1982, Johns Hopkins

Angelino S. Yson, MD — IM
3 Audubon Pl #430, Louisville 40217
1982, U of Philippines

Knott

Stephen P. Montgomery, MD — P
PO Box 1037, Hindman 41822
1989, U of Texas, Houston

Lawrence

Michael J. Pravetz, PhD, MD — P
PO Box 366, Louisa 41230
1982, U of Witwatersrand, S Africa

Madison

Patrick A. Kelleher, MD — IM
Box 128 Berea Hospital, Berea 40403
1974, Dartmouth

Marion

Richard L. Litt, MD — OBG
330 Loretto Rd #700, Lebanon 40033
1968, U of Florida

Marshall

Graham G. Smith, MD — FP
503 George McClain Dr, Benton 42025
1982, U of Saskatchewan

McCracken

Thomas M. Spagnolia, MD — NS
225 Medical Center Dr, Paducah 42002
1983, U of Missouri

Nelson

Franklin O. De La Cruz, MD — OBG
PO Box 367, Bardstown 40004
1982, U of CETEC

Maria Ramos, MD — AN
PO Box 367, Bardstown 40004
1988, U of Puerto Rico

Northern Kentucky

John J. Larkin, MD — ORS
10663 Montgomery Rd, Cincinnati 45242
1982, U of Kentucky
Frank R. Noyes, MD — ORS
621 E Mehring Way #415, Cincinnati 45202
1966, George Washington U
Mark G. Siegel, MD — ORS
621 E Mehring Way #414, Cincinnati 45202
1977, Boston U

Pike

Clarence D. Brown, MD — AN
116 Woodland Acres, Pikeville 41501
1971, Medical Col of Georgia
Sai P. Gutti, MD — AN
186 Harold Branch Rd, Pikeville 41501
1982, Rangaraya Med Col, India
Brahmaji S. Puram, MD — IM
Pikeville Methodist Hosp, Pikeville 41501
1974, Andhra U, India
Vijayalakshmi Puram, MD — HEM
Pikeville Methodist Hosp, Pikeville 41501
1971, Guntur Med Col, India

Scott

Robert C. Martin, MD — IM
1140 Lexington Rd #200, Georgetown 40324
1990, West Virginia U

Warren

Paul B. Cofoid, MD — END
1600 Applegate Ct, Bowling Green 42101
1971, Saint Louis U
Gary J. Fortune, DO — PM
79 Deer Meadow Ave, Bowling Green 42103
1984, Kirksville Col of Osteopathic Med
Thomas L. Schneider, MD — END
600 Corvett Dr, Bowling Green 42102
1975, U of Cincinnati

In-Training

Fayette

Mohamad Alnahhas, MD — PD
Tuesday Bigelow, MD — OTO
Yoland M. Musgrave, MD — PTH

Jefferson

Jeanie M. Branconi, MD — FP
Scott C. Grevey, MD — D
Ana Rowena A. Overley, MD — IM
Richard B. Seither, MD — ONC
Sheron R. Williams, MD — IM

DEATHS

Joan K. Mattingly, MD
Lexington
1936-1993

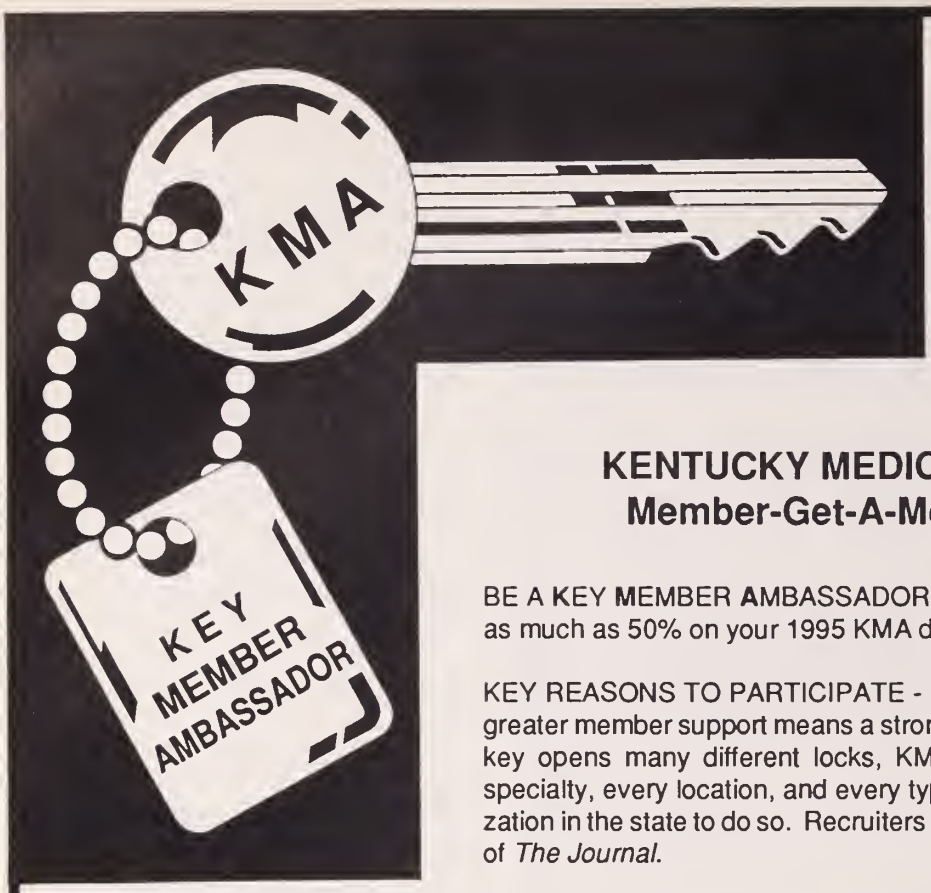
Joan K. Mattingly, MD, a general practitioner, died October 18, 1993. A 1962 graduate of the University of Louisville School of Medicine, Dr Mattingly had been an active member of KMA.

Mary V. Franz, MD
Louisville
1910-1993

Mary V. Franz, MD, a retired public health physician, died October 19, 1993. A 1935 graduate of the University of Louisville School of Medicine, Dr Franz was a life member of KMA.

Norma T. Shepherd, MD
Hopkinsville
1918-1993

Norma T. Shepherd, MD, a retired family practitioner, died October 19, 1993. Dr Shepherd was a 1945 graduate of the University of Nebraska College of Medicine and a life member of KMA.



YOU are the KEY to the

KENTUCKY MEDICAL ASSOCIATION
Member-Get-A-Member Campaign

BE A KEY MEMBER AMBASSADOR - and unlock the opportunity to save as much as 50% on your 1995 KMA dues!

KEY REASONS TO PARTICIPATE - Besides the dues incentive to you. . . greater member support means a stronger, more unified, voice. As a master key opens many different locks, KMA represents physicians from every specialty, every location, and every type of practice - and is the only organization in the state to do so. Recruiters will also be recognized in future issues of *The Journal.*

KEY PROSPECTS - New physicians in your area, hospital staff colleagues, alumni from your medical school, physicians in your specialty, or nonmembers in a particular target group, eg, women physicians, faculty, international medical graduates - take your pick.

KEY TO RECRUITMENT - The most effective way to recruit new members is through a **personal** conversation or note conveying your own thoughts about why you are a member. Special recruiter kits containing brochures and information on benefits are available for your use.

- OPEN THE DOOR FOR DUES DISCOUNTS -

The campaign targets1994 membership. As a KMA Key Member Ambassador, the credit you earn for any new member joining before **April 1, 1994,** will be applied to your 1995 KMA dues. You hold the KEY to the amount of the discount:

Recruit				KMA Dues Discount
1-2	new members	-	earn a	10%
3-5	new members	-	earn a	20%
6-9	new members	-	earn a	30%
10+	new members	-	earn a	50%

YES, I'm interested in the Member-Get-A-Member campaign. Send me a recruiter kit.

Name _____

Address _____

_____

Phone _____

I'd like a list of potential members:

- ❒ In my county
- ❒ In my specialty
- ❒ From my medical school class
- ❒ Faculty at my school
- ❒ Women
- ❒ International medical graduates

Mail to: *KMA Membership Dept., 301 N. Hurstbourne Pky, #200, Louisville, KY 40222-8512. Or call, (502) 426-6200.*

American Medical Association
Physicians dedicated to the health of America

For Your Benefit

AMA brings physicians' system reform concerns to Washington

The AMA continues to work with the Clinton administration and Congress to be sure health system reform preserves the physician-patient relationship. Since introducing the Health Access America proposal in 1990, the AMA has been at the forefront of the health system reform debate.

Many basic principles of Health Access America are mirrored in Clinton's proposal: universal coverage, a national package of health benefits emphasizing preventive care, an employer mandate and insurance reform.

"Both plans seek to build on what already works in health care, and both would make certain that the health care system works fairly for all Americans," said AMA Executive Vice President James S. Todd, MD, in testimony before the Senate Labor and Human Resources Committee.

Dr. Todd also took the opportunity to express concern that the plan does not include "the necessary level of physician participation on behalf of patients."

In testimony before the House Committee on Energy and Commerce, AMA Chair Lonnie R. Bristow, MD, detailed the AMA's differences with the Clinton proposal.

Complicated levels of government regulations built into Clinton's plan cause concern. Dr. Bristow said such levels will add new layers of bureaucracy through the proposed national health board and state-run health facilities.

The plan does not go far enough to limit medical liability costs through caps on non-economic damages and meaningful limits on attorney fees, Dr. Bristow said. More antitrust relief also is needed to allow physicians to adequately negotiate with large managed care organizations.

Dr. Bristow rejected the rigid budget caps and targets in Clinton's plan. Instead, he suggested developing prospective growth targets that establish flexible spending goals for the health care sector of the economy. These goals would identify specific cost difficulties and solutions. Targets would also allow for meaningful negotiations between physicians and the government.

Dr. Bristow expressed medicine's concern over Clinton's intent to regulate the percentage of physicians in primary care to 50 percent and to control allocation of residency slots.

The AMA's litmus test for the Clinton reform legislation consists of only two questions: Will patients have the freedom to obtain care from the provider and facility of their choice? And, can physicians provide necessary, effective and efficient care without undue restrictions on their clinical judgment?

Prepared by the AMA Department of Communications Services. For information, call 800 AMA-3211, ext. 4416.

Fund-raising begins for new Physicians Health Foundation

A mass mailing has been sent to all AMA members and nonmembers requesting donations to fund the Association's newly established Physicians Health Foundation.

The new foundation, developed to provide economic assistance and retraining to disabled and unemployed physicians, will conduct a similar fund-raising campaign each year.

Physicians Health Foundation will work closely with state medical society-sponsored physician assistance programs, which actively will seek out and identify impaired or disabled physicians who need assistance.

Donations will provide economic help to disabled physicians until they are able to return to work or find other means of financial assistance.

The funds also will support and develop retraining programs for disabled physicians and expand on the AMA's current career placement service.

To make a donation, write AMA Physicians Health Foundation, Floor 8, AMA, 515 N. State St., Chicago, Ill. 60610. For more information, call Jean Owens, (800) 621-3211, ext. 5066.

AMA speakers bureau offers health system reform updates

Physicians and health policy professionals are available to deliver presentations through the AMA's Health System Reform Speakers Bureau.

The AMA speakers bureau has been established to strengthen and enhance organized medicine's health system reform position by giving presentations on reform to state and local medical communities as well as to the public.

AMA speakers are reaching numerous physicians and citizens across the nation, providing health system reform updates and explaining how each can help influence the reform process at the grass roots level.

The bureau also provides physicians with prepared speeches, talking points and other materials to help them with their own local presentations on health system reform.

For information on the AMA's speakers bureau or to schedule a speaker, call Marcia Moore, (800) 621-3211, ext. 4710.

HCFA responds to AMA, revises Medicare policy

Responding to concerns expressed by the AMA and other physician organizations, HCFA revised its policy to allow physicians to bill patients for noncovered visit services provided as part of routine physical exams.

Although Medicare does not cover routine physical exams, physicians were able to bill patients at regular fees for these services prior to May 1992. HCFA then revised its policy so physicians could not divide the visit into covered and noncovered portions.

The new policy, effective Oct. 30, enables physicians to bill Medicare for covered visit services. Payment is the lesser of the physician's actual charge or the Medicare-approved amount, if the physician accepts assignment. If assignment is not accepted, payment is the lesser of the actual charge or limiting charge.

The physician's charge to the patient for the noncovered portion of the E/M service is the difference between the physician's usual fee for a routine physical exam and the usual fee (not the Medicare-allowed amount) for the covered visit.

For information, call the AMA Dept. of Health Care Financing, (800) 262-3211, ext. 4514.

Prepared by the AMA Department of Communications Services. For information, call 800 AMA-3211, ext. 4416.

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

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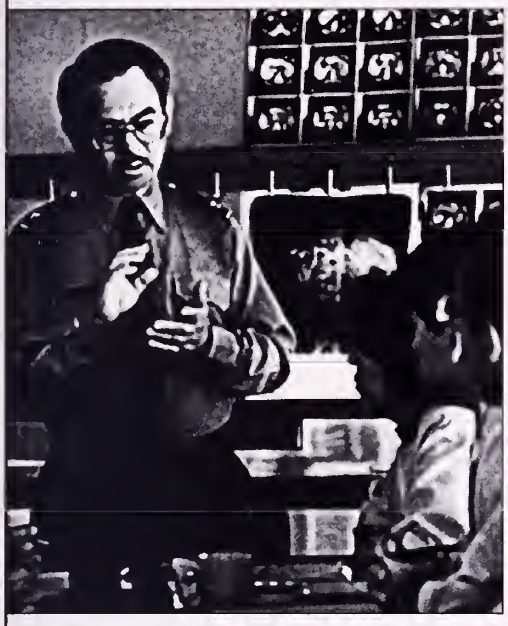
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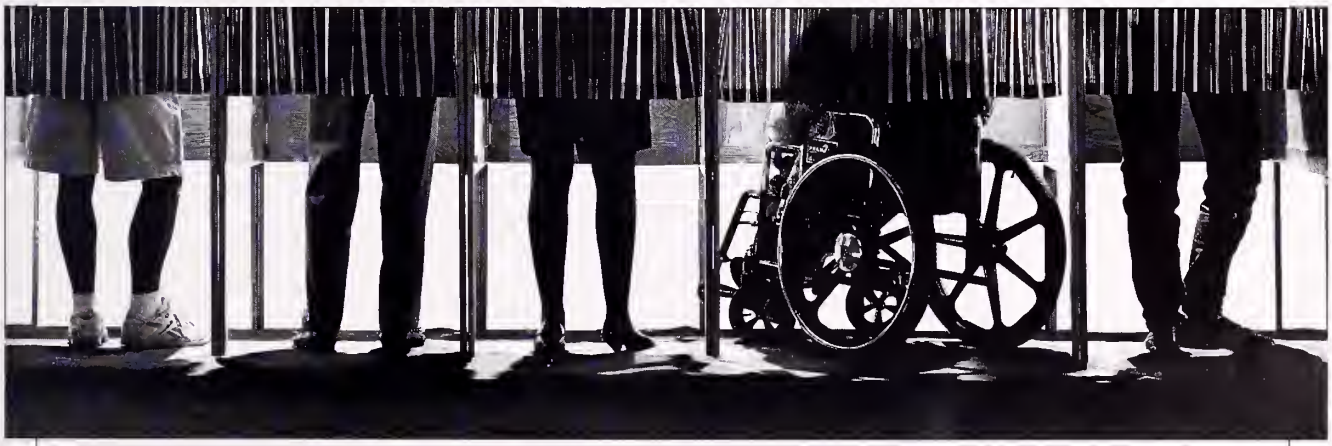
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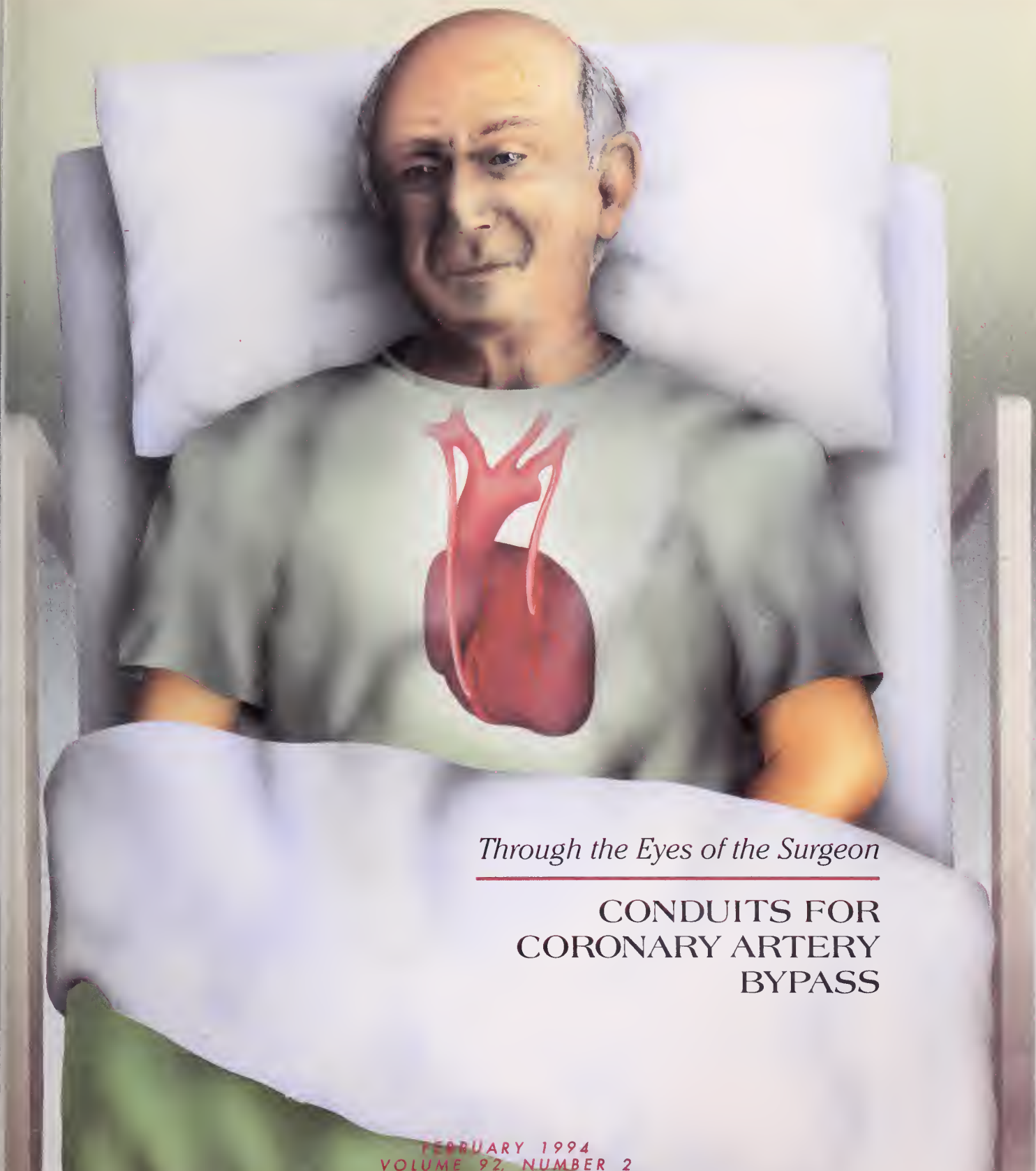
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CONDUITS FOR CORONARY ARTERY BYPASS

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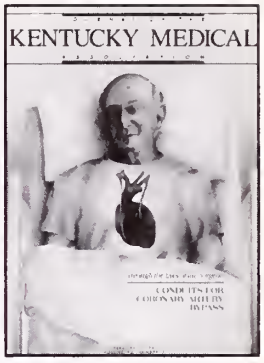
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***COVER:** Louisville surgeons discuss new conduits for coronory ortery bypass patients. See orticle on poge 52. Cover ort illustrotes the recovering bypass patient through the eyes of the cordiothorocic surgeon.* With permission to reprint from Poul Spence, MD.
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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Second-class postage paid at Louisville, KY and additional offices. Yearly subscription rates: $25 domestic; $30 foreign. Single issues $3 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association,* 301 N Hurstbourne Pkwy, Suite 200, Louisville, KY 40222-8512. EDITORIAL AND ADVERTISING: Telephone 502/426-6200.

Listed in Index Medicus. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

National advertising representative: State Medical Journal Advertising Bureau, Inc, 11437 W 106th St, Overland Park, KS 66214, phone 800/788-2360.

The *Journal,* its editors, and the Kentucky Medical Association do not assume responsibility for the opinions and statements of its contributors and advertisers. The *Journal* reserves the right to make the final decision on all content and advertisements.

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Your Representation



William H. Mitchell, MD

The physicians who founded and constituted the Kentucky Medical Association reflected their wisdom by establishing a Board of Trustees and a House of Delegates. The Association's political structure closely resembles our national government in that we have direct local, state, and national representation into our organization.

The House of Delegates reflects representation on the basis of physician population. The more KMA members in the county, the more delegate representatives can be sent to the House of Delegates.

The House of Delegates, therefore, is analogous to the House of Representatives in the United States government.

The Board of Trustees, on the other hand, has equal representation for every district in Kentucky, regardless of the population of physicians in that district. One trustee has one vote and that vote is equal to the vote of any other trustee, no matter what district is represented.

In that respect, the Board of Trustees is analogous to the Senate in the United States government.

There is no doubt that the House of Delegates approves and sets policy for the organization. Issues are brought to the House of Delegates through the Board of Trustees, its Executive Committee, individual county medical societies, and individual delegates or members through resolutions or reports of KMA committees.

The main business of the Board of Trustees is the representation of physicians in our individual trustee districts. The importance of that work is to convey and express the feelings and opinions of the physicians we represent. That information is used and incorporated in the formulation of policy. When this is done, policy is truly representative of the physicians in Kentucky. If we succeed in doing this, we will be fulfilling a goal set by the founders of the organization.

We wrestle in our minds with the concept of "political realities." The main emphasis of the organization is "what is best for our patients and our profession." We cannot reach what is in the best interest of our patients and our profession in any manner that is not truly representative of the real feelings and the real perceptions of the physicians represented by each trustee.

When we don't have this information, not only some physicians, but groups of physicians begin to feel left out, "out of the loop," and consequently alienated from the activities of the organization.

There are many opportunities for "grass roots" input to KMA. Direct contact with your Trustee is the most obvious. Members can also make their feelings known to KMA through their county medical society, the KMA committee structure, resolutions to the House of Delegates, through direct contact with the officers of the Association, or by contacting the KMA Headquarters Office and speaking with a member of the staff.

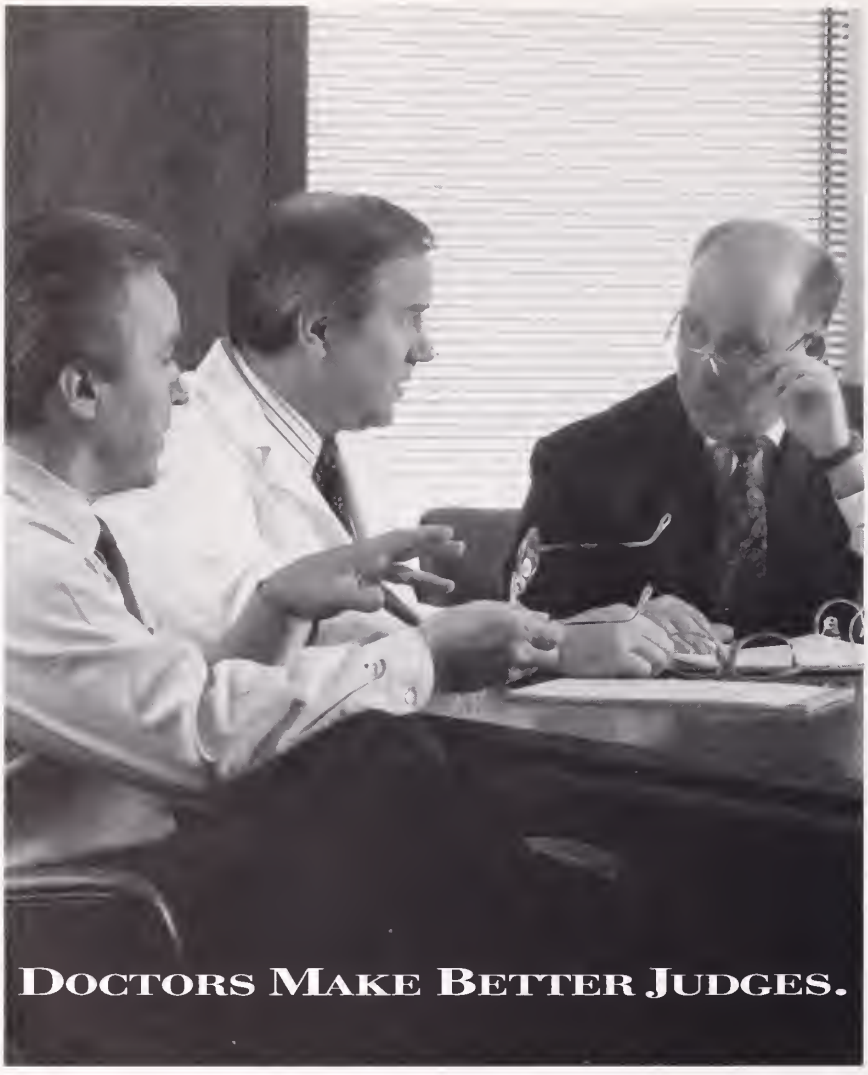
A few years ago, KMA delegates representing small rural counties began meeting together as the Rural Caucus of the KMA House of Delegates in an effort to better coordinate activities and positions important to physicians in rural areas. The Rural Caucus provides delegates from small towns or rural communities the opportunity to work within the KMA structure to make sure their views are considered.

I encourage each county to work to elect your delegates to KMA and to be sure that your delegate attends House of Delegates meetings. Some delegates, because of practice pressures or other reasons, cannot attend. For example, this year, 319 delegates were eligible to participate in the House, but 196 registered. Twenty-three counties did not report any delegates, yet each was eligible to send at least one.

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William H. Mitchell, MD
KMA Vice President

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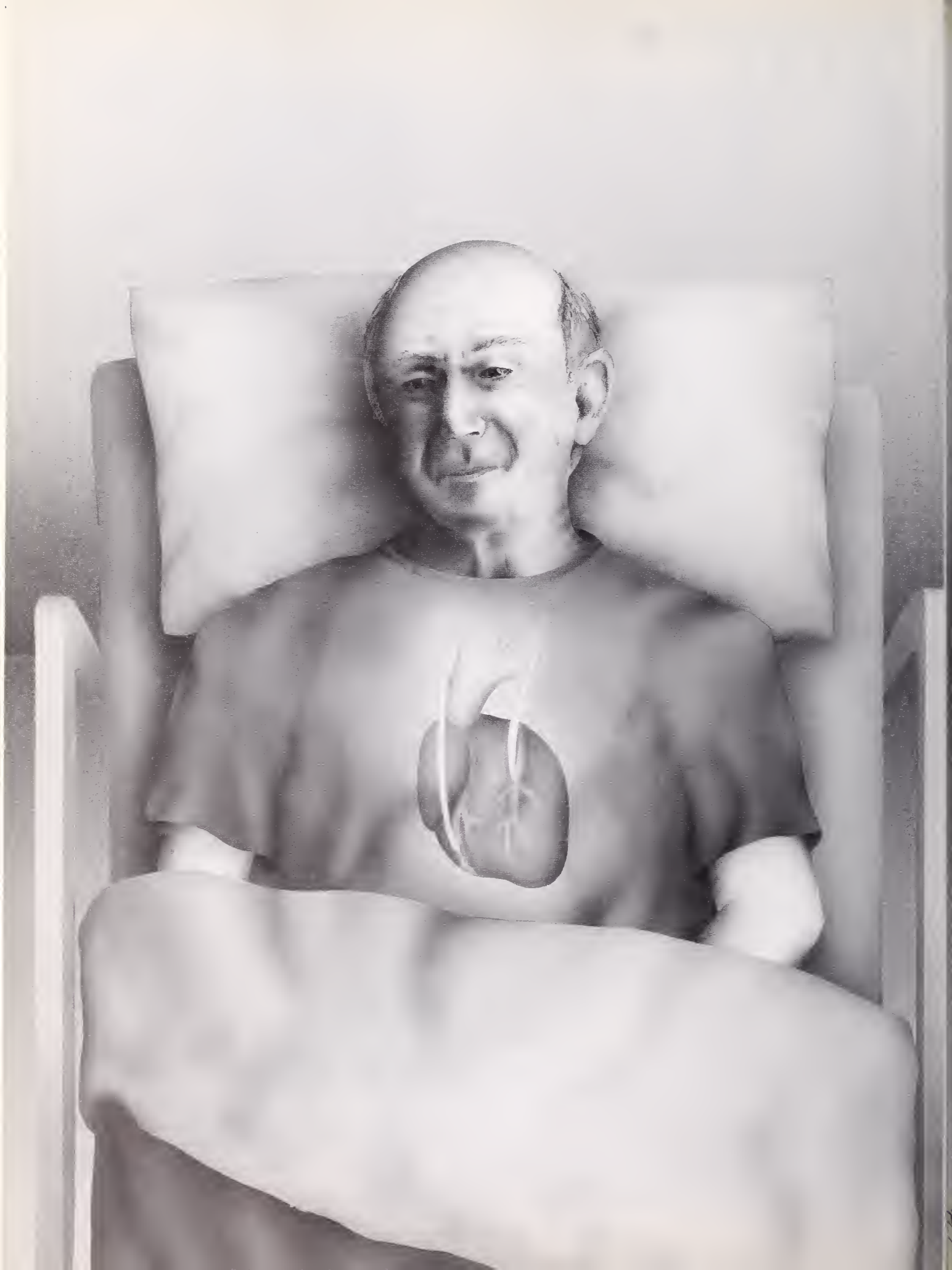
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New Conduits for Coronary Artery Bypass: Great Promise for Improved Outcome from Coronary Artery Surgery

Paul A. Spence, MD; Laman A. Gray, Jr, MD

The internal mammary artery is the conduit of choice for coronary artery bypass, with patency at about 95%, 10 years after implantation. Patients who receive this graft survive longer and have fewer cardiac complications than those who receive only saphenous vein bypass grafts. Surgeons are currently studying other arteries that may be used as bypass conduits. The gastroepiploic artery on the greater curve of the stomach demonstrates the greatest promise, with patency greater than 90% at 3 to 4 years. The radial artery, used in the 1970s but abandoned due to poor results, may be due for a revival, since it has up to 95% patency at one year. The inferior epigastric artery (located posterior to the rectus muscle) is also under consideration, but few results are available. However, it appears that about 80% are patent at one year. The role of these alternative conduits has not yet been clarified in the management of coronary bypass patients. However, these preliminary observations suggest that increased use of these extremely durable bypass conduits may further improve surgical outcomes.

Unequivocal improved patient survival and outcome are the main reasons why the internal mammary artery is the current conduit of choice for coronary artery bypass procedures.[1] Routine coronary artery bypass procedures at most centers involve the use of the internal mammary artery for grafts to the left anterior descending coronary artery, and the addition of vein grafts to other diseased coronary arteries. Unless there is a contraindication for using this conduit, our center always uses the internal mammary artery.

The internal mammary artery was the first artery used for myocardial revascularization. Instead of being anastomosed to a coronary artery, it was implanted into the myocardium.[2] Side branches were not ligated intentionally so that they could attach to the circulation within the myocardium in order to perfuse it. The first direct internal mammary artery to coronary artery anastomosis was performed by Kolesow in Moscow in 1964.[3] (Knowledge of this procedure did not reach the West until much later.) In the West, Rene Favoloro is credited with performing the first direct coronary bypass operation by anastomosis of a segment of saphenous vein to the left anterior descending coronary artery in 1967.[4] The following year in New York, Green used the left internal mammary artery to revascularize the left anterior descending coronary.[5]

Although the internal mammary artery and the saphenous vein were both used initially for coronary surgery, the use of the saphenous vein soon dominated. The internal mammary artery was much more difficult to harvest because of its numerous side branches that attach it to the posterior aspect of the chest wall. Furthermore, because it was smaller and considerably more delicate, it was also more difficult to construct a free-flowing and hemostatic anastomosis. In contrast, the saphenous vein was larger, easier to harvest, available in large quantities, and was simpler to anastomose. For these reasons, it was not surprising that in the absence of data regarding long-term outcome, surgeons usually preferred to use the saphenous vein as a conduit for coronary surgery.

When new research demonstrated improved outcomes with a single internal mammary artery graft, it was not surprising that interest shifted from the saphenous vein to the internal mammary arteries.[1] Most surgeons were impressed by the fact that patency for the internal mammary artery was about 95% at 5 and 10 years after surgery.

From the Division of Thoracic and Cardiovascular Surgery, Department of Surgery, University of Louisville School of Medicine, Louisville, KY.

Reprint requests to Department of Surgery, Editorial Office, University of Louisville, Louisville, KY 40292 (Dr Spence). Phone 502/852-1895.

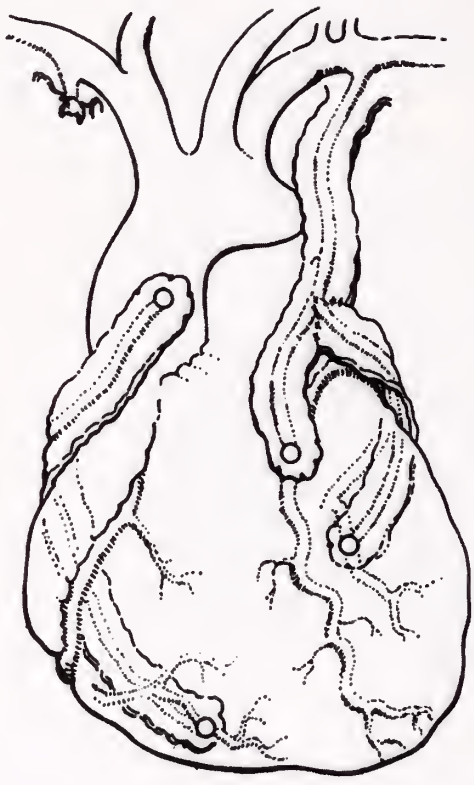


Fig 1 — A pedicled (attached ta the left subclavion) left internol mommary artery graft is onostomosed to the left anteriar descending coronory ortery. A segment token fram the distol end of this same left internal mammory is anastamased (end-to-side) to the praximal left internol mammary and wropped oraund the left side af the heart ta supply on obtuse morginol bronch af the circumflex coronary artery (T ar X graft). A free (detoched from the subclovian) right internal mammary ortery is onostomosed to the oarta ond supplies flaw ta the posterior descending bronch af the right caranary artery.

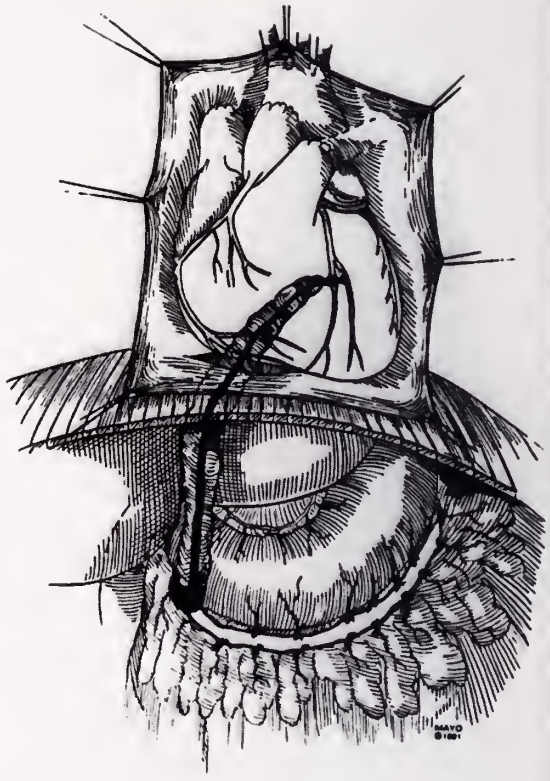


Fig 2 — The right gostraepiplaic artery has been horvested fram the greoter curve af the stamach and anastamosed to the left anteriar descending coronary artery. A defect must be made in the diaphragm to tollow this graft to enter the thorox.

Soon surgeons began to perform routine bilateral internal mammary artery bypasses, while others extended the use of the mammary artery by grafting numerous coronary vessels with one internal mammary artery (sequential grafting) (Fig 1).[6] More innovations were described when surgeons began to take segments of internal mammary arteries and 'T' them off to graft additional vessels.[7] To date, there is no data to confirm that patients who receive extensive mammary artery grafting have improved survival or fewer complications. Perhaps part of the problem is that the results of a single internal mammary artery graft are so good that it is difficult to demonstrate the benefits of a second graft.

Newer Arterial Conduits

The key to the success of the internal mammary artery graft has been its amazing resistance to the development of atherosclerotic disease. When harvested, and even after many years in circulation as conduits, these grafts are still resistant to disease. In contrast, after about 5 years in circulation, most saphenous vein grafts demonstrate atherosclerotic changes, and by 10 years, about one-third of saphenous vein grafts are occluded.[8] Unfortunately, there is a limit to the number of bypasses that can be performed with mammary artery grafts. For the most part, each internal mammary artery is used to graft only one target vessel. Thus, a typical patient undergoing a four-

vessel bypass would receive, at most, two mammary artery grafts (one left and one right internal mammary artery graft). The other grafts are generally performed with saphenous vein segments. In an effort to increase the use of conduits that could be potentially more resistant to disease, surgeons began to expand their use of other arterial conduits.

The Gastroepiploic Artery. The right gastroepiploic artery runs along the greater curve of the stomach. It is largest close to the pylorus, and it tapers as it courses along the greater curve of the stomach as it approaches the spleen. The artery has many branches to the stomach, but these can be divided, allowing for a pedicled graft up to 20 cm long. The artery can then be tunneled through the diaphragm and used as a bypass conduit (Fig 2).

Few centers have reported results using this conduit, but most reports are promising. In fact, the early indications of its performance are comparable to that of the internal mammary artery graft. Early reports state that about 95% of these grafts are patent between 2 and 4 years after bypass.[9] Unfortunately, since there are few centers using this conduit, many surgeons are reluctant to use it more often.

From a technical viewpoint, the gastroepiploic artery is more difficult to handle and suture and is prone to spasm. Perioperative spasm may result in an unacceptably high infarction rate at the time of surgery. Disease in the celiac axis may also limit the inflow to the gastroepiploic artery and result in insufficient graft flow. During subsequent abdominal surgery, this graft may be inadvertently divided, causing serious consequences. Currently, however, the gastroepiploic artery appears to be the arterial conduit next in line to replace the internal mammary artery. Further observations will be necessary to determine its role.

The Inferior Epigastric Artery. The inferior epigastric artery runs in the posterior rectus sheath behind the rectus muscle (Fig 3). It can be harvested through a vertical incision off the midline by retracting the rectus muscle anteriorly and ligating side branches (Fig 4), beginning near the level of the external iliac artery and continuing up to the region of the umbilicus. This artery must be used as a free graft (ie, both ends are divided and the artery is transplanted into the chest). One end is sewn to the aorta and the other to the coronary artery beyond the obstruction, similar to a saphenous vein graft. In this respect, it differs

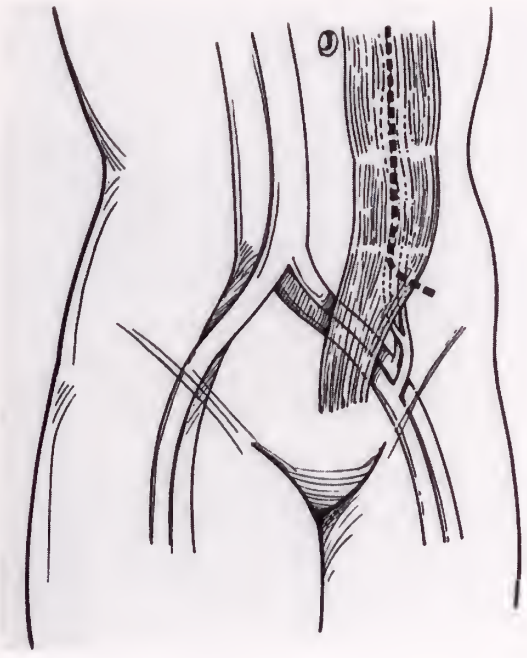


Fig 3 — The inferior epigastric artery is demonstrated posterior to the rectus abdominous muscle. A proposed incision is demonstrated with a dotted line.

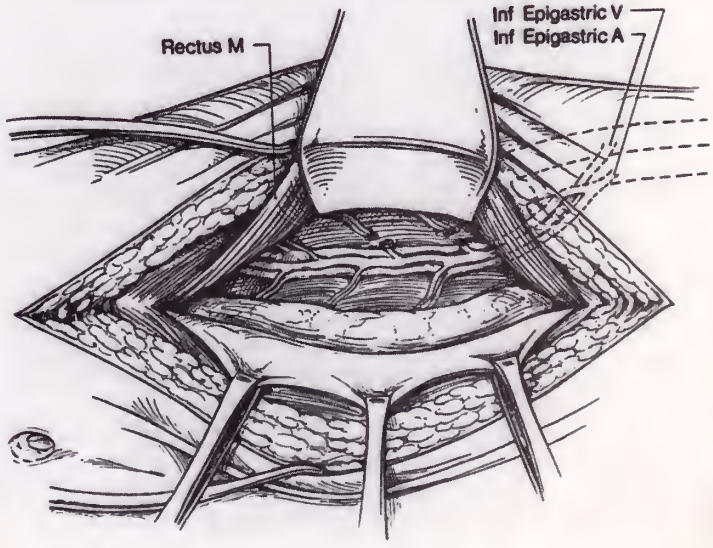


Fig 4 — The rectus muscle is retracted upward demonstrating the inferior epigastric artery and accompanying veins. Abbreviations: Rectus M, rectus muscle; inf epigastric V, inferior epigastric vessel; inf epigastric A, inferior epigastric artery.

Table I. Newer Arterial Conduits

Canduit	Patency	Comment
Internal mammary artery	95% at 10 years	The ideal canduit currently available
Gastraepiplaic artery	95% at 3-4 years	Currently the best alternate arterial canduit
Radial artery	95% at 1 year	Subject ta spasm and early occlusian withaut lang-term oral calcium channel blackers
Inferiar epigastric artery	80% at 1 year	No data available after 1 year of implantatian

from both the internal mammary artery and the gastroepiploic artery, which are generally used as pedicled grafts. (The internal mammary artery has inflow from the subclavian artery and the gastroepiploic artery from the abdominal aorta via the celiac axis.)

There is little data available regarding the results of bypass with this conduit.[10] To the best of our knowledge, the only follow-up is from Dr Dion in Brussels, Belgium, who reported about 80% patency at 1 year after bypass (personal communication). Interestingly, their saphenous vein graft patency was superior — almost 90% at one year. It is unclear whether early failure will continue or whether this graft will have an early period of attrition and then virtually unlimited patency subsequently (similar to the pattern obtained with the internal mammary artery).

Free arterial grafts (non-pedicled) seem to have a much lower patency rate than pedicled grafts. Even the internal mammary artery and the gastroepiploic artery, when used as free conduits, fare less well than their pedicled counterparts. The reason for this is uncertain, but it has been suggested that the additional anastomosis on the aorta is responsible. However, this explanation appears to be too simple and other factors may be involved. One possible explanation may be that free arterial grafts are denervated (by necessity when they are excised) and become hypersensitive to circulating catecholamines, leading to spasm and occlusion. Spasm in the inferior epigastric artery grafts is seen frequently during follow-up in the postoperative period.

The Radial Artery. The radial artery was used during the initial development of coronary bypass surgery, but its use was abandoned by the mid 1970s. Early graft occlusion was reported by a wide variety of surgical centers.[11,12] In fact, up to 50% of the grafts were occluded within 6 months after surgery. When coupled with the potential for hand ischemia, there was little justification for its continued use.

Recently, however, the use of the radial artery as a conduit has been resurrected in France. A group of surgeons in Paris began using these arteries again, and the patients were placed on calcium channel blockers.[13] Patency was remarkably improved, with over 90% patency at 1 year. It was interesting that their postoperative angiograms showed a considerable amount of graft spasm, despite the chronic administration of calcium channel blockers. Their results suggest that early failure with radial artery grafts may have resulted from spasm, which has only recently been improved by the use of calcium channel blockers. This exciting observation has led many to wonder whether all patients who receive free arterial grafts may benefit from the use of calcium channel blockers.

Other Arterial Conduits. A number of other arterial conduits have been used recently. The splenic artery can be harvested as a free graft and used as a bypass graft.[14] In addition, some surgeons have started to harvest the subscapular artery from behind the scapula for use as a bypass conduit.[15] However, this research is still so new that no follow-up data is currently available.

Problems with Arterial Conduits

One problem with using an arterial conduit is that the site from which it is removed may become ischemic. Fortunately, tissue ischemia at the harvest site is uncommon for the arteries mentioned in Table 1. Sternal complications may be slightly more common when two mammary arteries are used, particularly in diabetic patients who are insulin-dependent.[6] Fortunately, ischemia of the stomach with the gastroepiploic artery bypass or ischemia of the abdominal wall with the inferior epigastric artery bypass is not common. When selecting an arterial graft, one must also consider the effect of harvesting on the donor site.

The potential for graft spasm is another serious concern. As mentioned previously, spasm is known to occur with radial grafts as well as most of the other free arterial grafts.[13] Extreme spasm may promote early graft failure. The vast improvement in patency of the radial artery graft after the use of calcium channel blockers suggests that these may be important drugs, and that they

should be used in all patients with free arterial grafts.

Acute ischemia may be due to the fact that arterial grafts are generally smaller than vein grafts. Myocardial demands are unusually high at surgery and a small arterial conduit, especially with a minimal amount of spasm, may not be able to supply an adequate amount of flow.[16] Some surgeons have recommended adding both a mammary artery graft and a vein graft to one coronary vessel when the mammary graft is small. The internal mammary artery is used because of its long-term patency and the saphenous vein graft because of its immediate ability to improve flow. The results of combined artery and vein are not known, but it is possible that there may be an adverse effect on the mammary artery graft because of the high flow rate from the saphenous vein graft.

Soon after mammary artery grafts were first introduced, some surgeons began describing the artery as shriveled and shrunken when used to graft a vessel with a small amount of obstruction.[17] Many confirmed the observation that high flow from a native vessel causes the mammary artery to shrivel,[18] but the level of obstruction that must be present before the internal mammary artery is subject to this problem is not known. Fortunately, the internal mammary artery appears to be able to reexpand and increase its flow when the native vessel becomes progressively more occluded. Further investigation into this problem could bear other rewards. Most patients are not operated on until they have three-vessel disease. If disease-resistant grafts could be applied to hemodynamically obstructed vessels as well as to vessels with minimal disease, a more cost-effective management of patients could result. Rather than repeat medication adjustment, treadmill testing, and angioplasty, it is just possible that patients could have all arteries treated (whether diseased or prophylactically) during one procedure.[19]

Current Clinical Practice

Although arterial conduits offer promise, until there is more evidence of their superiority, the most prudent choice for most patients appears to be the continued use of a single internal mammary artery and multiple vein grafts. In patients who are very young or at exceptionally high risk for recurrent disease, bilateral internal mammary artery grafting, coupled with use of the gastroepiploic artery, may be a reasonable option. We hope to see reports on the results of this combination in the literature in the next few years. It is possible that expanded use of these grafts may reduce the need for further cardiac interventions and reduce the overall treatment cost for these patients. This aspect of patient care may be an important, cost-effective, determinant in the conduit selection process.

Conduit selection is even more complex in patients who have no saphenous vein available. Some patients have such severe varicosities that the vein is unusable as a conduit. Others have undergone bilateral complete saphenous vein stripping. For these patients, the remaining short saphenous vein in the posterior calf or a vein from the arm may be considered. When ranking arterial grafts according to confirmed reliability, one should first use both internal mammary arteries, then the gastroepiploic artery, followed by the inferior epigastric artery if necessary. However, this priority may change as more results become available.

Conclusions

Surgeons continue to search for the conduit material that would rival the high patency of the internal mammary artery graft. Bilateral and extended internal mammary artery grafting have been explored, and more recently, the use of the gastroepiploic artery and the inferior epigastric artery has been described. The results of the gastroepiploic artery graft appear to be the most promising, with a patency similar to the internal mammary artery at 2 to 4 years after bypass. The inferior epigastric artery has a patency similar to the saphenous vein at 1 year, but no information is available for periods longer than that. The once infamous radial artery conduit has been revived with good results. However, surgeons are still influenced by the previous failures with this conduit and by the risk of hand ischemia.

These investigations may potentially lead to a highly cost-effective treatment for coronary artery disease. If a single surgical intervention can produce a prolonged intervention-free and symptom-free period for the patient at an early stage in the disease, both the patient and the entire medical system will be rewarded.

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Pulmonary Fibrosis and Occupational Exposure to Aluminum

Ammar Al-Masalkhi, MD; Stephanie Prater Walton, MD

Many reports of respiratory disease attributable to aluminum exposure have appeared in the European medical literature during the last 50 years. Great Britain and Germany are two major industrialized nations that acknowledge a causal relationship between occupational exposure to aluminum and respiratory impairment. For factory workers in these countries, pulmonary disease attributed to respirable aluminum particulates is compensated as a workplace disability.

In North America, however, there is a lack of consensus regarding the pathogenicity of aluminum fumes and dust to the worker. This view may be based on a difference in the types of industrial usage, the updated methods of aluminum processing in this country, or the benefits of a modern workplace. It has also been proposed that the development of aluminum-induced pulmonary disease may depend on a particular host factor that has not yet been identified. We describe a patient whom we believe developed severe respiratory compromise and irreversible pulmonary fibrosis from a lifetime of industrial aluminum exposure.

The natural abrasive properties of aluminum make it a favorite material for the production of grinding wheels and cutting tools. Short term studies suggest that it is less harmful to workers than other available natural abrasives such as asbestos.[1]

Aluminum oxide fumes and respirable aluminum particles are by-products of the manufacturing processes that employ this metal. In 1981, Wegman and Eisen demonstrated an excess of malignant and nonmalignant lung disease in North American aluminum workers.[2] These workers were engaged primarily in the production of grinding tools with an aluminum oxide tip.

Subsequent studies of industrial exposure to aerosolized aluminum have provided additional clinical and radiographic evidence that aluminum can cause pulmonary impairment in susceptible individuals. Aluminum exposure has now been implicated as a precipitating factor for interstitial pulmonary fibrosis, reactive airways disease, and chronic obstructive lung disease.[3]

The pathologic confirmation of aluminum-induced lung disease requires a sophisticated battery of histologic and electron micrograph studies. Because this type of tissue analysis is not readily available, we suspect that the number of affected individuals may be underestimated.

From the Division of Internol Medicine, University of Louisville School of Medicine, 550 S Jackson St, ACB-3, Louisville, KY 40292.

Case Report

A 62-year-old white male was admitted to the Louisville Veterans Administration Medical Center with exertional dyspnea. He also complained of presyncopal episodes that were precipitated by activity and changes in position. He had voluntarily curtailed his physical activity over the 2 years prior to admission to balance a gradual but progressive decline in his exercise tolerance. The patient denied cough, fever, chills, malaise, or other constitutional symptoms.

He was a retired industrial engineer with a 23-year tenure in an aluminum producing plant. During the course of his work, he had regular, intermittent, significant exposures to aluminum oxide fumes that resulted from an aluminum production process. He was a lifetime nonsmoker and a suburban dweller. He did not have other exposure to known or environmental toxins. His family history was negative for pulmonary disease.

The patient presented in moderate respiratory distress. His respiratory rate was 30 breaths per minute. His heart rate was regular at 100 beats per minute. His other vital signs were normal. Examination of the oral cavity revealed pale mucus membranes with central cyanosis of the lips and the nose. The patient was using his accessory respiratory muscles to accomplish labored venti-

lation. Equal bilateral air movement was demonstrated. End-inspiratory bibasilar crackles were heard. The patient's fingers and toes showed the characteristic changes of digital "clubbing." Chronic venous stasis was apparent in both lower extremities.

The chest radiograph was interpreted as showing bilateral interstitial infiltrates (Fig 1). His electrocardiogram confirmed a sinus tachycardia, and suggested the development of right atrial enlargement and right ventricular conduction delay. Arterial blood gas analysis was performed while the patient was breathing room air. The PaO_2 was measured as 50 torr, $PaCO_2$ as 33 torr, and pH as 7.42. This pattern is consistent with hypoxemia and chronic hyperventilation. An echocardiogram showed right ventricular enlargement, mild tricuspid insufficiency, right atrial enlargement, and a patent foramen ovale with an insignificant resting right to left shunt.

Pulmonary function tests were consistent with a severe restrictive ventilatory defect. The diffusion capacity for carbon monoxide (DLCO) was reduced to 18% of the patient's predicted value. A gallium scan of the lungs failed to show evidence of active alveolitis. Fungal serologies, hypersensitivity profile, and collagen vascular screen were normal. Fiberoptic bronchoscopy with bronchoalveolar lavage (BAL) was performed. The samplings were negative for malignant cells or infectious pathogens. The BAL cell count and profile was unremarkable.

The patient's hypoxemia was relieved by the administration of low flow supplemental oxygen by nasal cannula. The patient declined to have an open lung biopsy after the risks of surgery were contrasted with the expected impact of tissue analysis on his treatment options.



Fig 1 — Bilateral fibrotic interstitial infiltrate.

Discussion

Early in this century, workers who manufactured aluminum abrasives or explosives from aluminum powders were noted to develop pulmonary fibrosis.[3] A causal link between lung disease and aluminum was delayed because multiple compounds with established fibrinogenic potential were common in this worksite. In the animal model, aluminum dust appeared to be less dangerous than the asbestos, coal, quartz, or silica needed for aluminum manufacturing.

Initial human studies relied on sputum analysis. The sputum of an aluminum worker was likely to contain an increased number of alveolar macrophages that had digested aluminum particles. However, asbestos fibers and silica crystals were also likely to be found in these macrophages. Although the radiographic picture of pulmonary fibrosis without pleural involvement or silicotic nodules argued against a primary role for asbestos or silica in the lung disease of the aluminum worker, occupational physicians were reluctant to attribute chest disease solely to aluminum exposure.

In 1947, Shaver reported 35 workers who developed pulmonary fibrosis after working the furnaces during aluminum production.[4] Ten of these individuals died of respiratory failure. Some critics dismissed Shaver's observations as consistent with accelerated silicosis. Other investigators provided additional reports of similar workers with apparent aluminum-induced pulmonary fibrosis without exposure to silicates.

These reports in the European and American medical literature provide the accepted profile of the patient with pulmonary fibrosis caused by exposure to aluminum dusts and fumes. The individual is typically male. Current or past tobacco

use is generally recorded. The average time spent in the aluminum industry is 25 years. Progressive dyspnea, nonproductive cough, and fatigue are the cardinal presenting symptoms. Pulmonary function is impaired and will show a restrictive ventilatory defect with a diminished diffusion capacity.[1] The chest radiograph reflects the presence of diffuse interstitial infiltrates that occur primarily in the upper lung zones.[5]

Confirmation that pulmonary fibrosis was caused by aluminum is still difficult. On light microscopy, the findings are nonspecific. Usual features include significant interstitial fibrosis and thickening, cellular infiltrate, and occasionally desquamative interstitial pneumonitis. A combination of electron microscopy and electron microprobe analysis is required to identify digested intracellular aluminum. Very small quantities of metallic aluminum particulate can be identified by energy dispersive spectrometry. To unequivocally attribute lung disease to aluminum exposure, this metal should be found in a concentration that exceeds other background fibers by at least 1000-fold.[6]

The analysis described above is expensive. The patient must be able and willing to undergo open lung surgery to provide an adequate biopsy sample. Special arrangements must be made to insure that the sophisticated energy dependent tests can be arranged. Obviously, these tests need to be interpreted by an experienced pathologist.

Unfortunately, as with a number of environmental diseases, the patient presents to his physician with significant cardiopulmonary disease that makes elective surgery undesirable. The lung biopsy may confirm the diagnostic suspicions of the clinician, but it usually fails to provide additional information that will help manage the patient's limitations.

In patients with suspected pulmonary interstitial disease from an occupational exposure, we recommend a few simple tests for assessing the degree of impairment and for planning the patient's treatment. A gallium scan will often indicate the presence of widespread alveolitis. This finding suggests that the patient should be removed from the inciting agent and receive therapy to prevent the development of irreversible fibrosis. An initial fiberoptic bronchoscopy offers the opportunity to exclude infectious processes or malignant diseases that can mimic pulmonary fibrosis. Bronchoalveolar lavage will provide a cell count that can suggest the likelihood of response to glucocorticoid therapy. Pulmonary function tests with diffusion capacity can be monitored periodically to determine the patient's response to therapy and/or the natural course of the illness.

Our patient reinforces the European attitude that occupational exposure to aluminum can present a potential respiratory hazard. Early recognition of a respiratory problem in an aluminum worker should prompt the clinician to consider this association. An early search for the presence of a reversible alveolitis will allow the physician to alter the patient's work exposure and offer the prompt treatment.

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Rapid Tests for the Diagnosis of *Legionella* Infections

Julio A. Ramirez, MD; James T. Summersgill, PhD

From the Infectious Diseoses Loborotory, Division of Infectious Diseases, University of Louisville School of Medicine, Louisville, KY 40292.

Three rapid tests are now available for the diagnosis of Legionella *infections: direct fluorescent antibody (DFA) assay, culture on selective media, and urinary antigen detection. A combination of the three tests constitutes a "*Legionella *Panel." The objective of this article is to present our experience with these assays and to discuss experimental tests that may further improve our capability to diagnose Legionnaires' disease. Diagnoses of* Legionella *infections were done in 11 of 549* Legionella *panels submitted to our reference laboratory. Six were positive for urinary antigen with corresponding negative DFA and culture; three had a positive DFA with negative culture and urinary antigen; and two had positive reactions for all three tests. The use of the* Legionella *panel offers a rapid, sensitive, and specific diagnosis of infection. The amplification of* Legionella *DNA in respiratory samples by the polymerase chain reaction method is a new diagnostic test that will further improve our ability to recognize and treat patients with* Legionella *infections.*

Legionnaires' Disease was first recognized following the legendary epidemic of pneumonia in Philadelphia at the American Legion convention of 1976.[1] Six months after the outbreak, the etiologic agent was determined by workers at the Centers for Disease Control[2] and was subsequently named *Legionella pneumophila*.

During the early investigation of the outbreak in Philadelphia it was felt that *Legionella* infections were rare and that *L pneumophila* was uncommon. It is clear now that this organism is responsible for a substantial number of cases of community-acquired and nosocomial pneumonia.[3,4]

L pneumophila is ubiquitous in aqueous environments[4] having been isolated from lakes, rivers, streams, and mud[4-7] and from manmade water systems such as fountains, fire sprinklers, car washes, plumbing systems, and water cooling systems used for air-conditioning or industrial purposes.[8-11] A great deal has been learned about the microbiology, ecology, and epidemiology of *Legionella* infections since their discovery in 1976.

Because the organism does not grow on standard bacteriologic media used in most hospital laboratories, the clinical diagnosis, until recently, was based on detection of anti-*Legionella* antibodies in acute and convalescent serum samples. This methodology is a valuable tool for epidemiological studies, but is usually of little help to the practicing physician when confronted with a patient with pneumonia. Three rapid tests are available to aid in the diagnosis of *Legionella* infections: direct fluorescent antibody assay (DFA), culture on selective media, and detection of *Legionella* urinary antigen. A combination of these three diagnostic tests comprise a "*Legionella* panel." The use of the "*Legionella* panel" allows the clinician to distinguish *Legionella* spp. from other bacterial etiologies during the initial evaluation of the patient with community-acquired or nosocomial pneumonia.

The objective of this paper is to present the experience of the Infectious Diseases Laboratory at the University of Louisville with these laboratory methods for rapid diagnosis of Legionnaires' Disease.

Material and Methods

Source of Specimens. The Infectious Diseases Laboratory at the University of Louisville is a reference laboratory which processes specimens from various hospitals in the region. For the purposes of this report, we have reviewed the results of 3,232 unsolicited and consecutive specimens received by our laboratory for *Legionella* workup between January 1, 1991, and September 14, 1992. Specimens were processed according to the

requesting physician's orders (DFA, culture, or urinary antigen detection). These could be requested as a single test or any combination of tests. In 549 respiratory and urine samples the three available tests, or "*Legionella* Panel," were requested.

Direct Fluorescent Antibody Assay (DFA). All respiratory specimens (sputum, transtracheal aspirate, bronchial washing, bronchoalveolar lavage, or lung biopsy) were examined for the presence of *L pneumophila*, by direct fluorescent antibody assay using a commercially available kit (Sanofi Diagnostics Pasteur, Chaska, MN). This kit utilizes a monoclonal antibody-based reagent which limits possible cross reaction with other microorganisms.

Briefly, the specimen is applied as a smear to a fluorescent microscope slide, allowed to air dry, and stained with a fluorescent-labelled antibody for 30 min at 37°C. The slide is washed with buffer, air dried, and examined using epifluorescence microscopy. The appearance of >5 bright apple-green bacilli per slide indicates the presence of *L pneumophila*.

Culture. Respiratory specimens were also processed for culture on selective bacteriologic media. All specimens were subjected to a 4 min acid wash (HCl/KCl, pH 2.2) prior to plating, by adding 100 µl of sample to 900 µl acid wash. Aliquots (100 µl) were then transferred to one each of buffered charcoal yeast extract agar (BCYE) (Difco, Detroit, MI) supplemented with 0.01% (w/v) L-cysteine and 0.05% ferric pyrophosphate and BCYE containing polymycin, anisomycin, and vancomycin (BCYE-PAV) (Remel, Lenexa, KS). Plates were incubated at 37°C and examined under a dissecting stereoscope daily for 10 days. *Legionella* colonies appear rounded with a cut-glass texture, often with a reddish border. Colonies of *Legionella* normally do not become visible on the agar surface until after 3 days of incubation.

Urinary Antigen Detection. All urine samples were processed on the day of receipt using a radio-immunoassay kit (**Equate** *Legionella*, Binax, Inc, S Portland, ME) designed to detect *L pneumophila*, serogroup 1, antigenuria. Briefly, the procedure involves the addition of 100 µl of sample into the antibody-coated tubes, followed by a 1.0 hr incubation at 37°C. All samples are then aspirated from each tube, followed by three washes with 0.15% NaCl (pH 7.2). The radio-labeled (^{125}I) detection antibody (100 µl) is added to each tube, followed by an additional 1 hr incubation at 37°C. A second wash (×3) follows and all tubes are read in a gamma counter for 1 min. Urine samples with a Sample Count to Negative Count ratio of >3.0 were considered positive.

Table 1. 3,232 Specimens for *Legionella* Testing

	Urine Ag	DFA	Culture
Positive	14	10	4
Negative	1,505	774	925
Total	1,519	784	929

Table 2. Results of 11/549 Positive *Legionella* Panels

No.	Urine Ag	DFA	Culture
6	+	–	–
3	–	+	–
2	+	+	+

Results

As seen in Table 1, the Infectious Diseases Laboratory processed 784 specimens by DFA, 929 by culture, and 1,519 by detection of urinary antigen during the 21-month period examined. Fourteen urine specimens were positive for *Legionella* urinary antigen, 10 specimens were positive by DFA and 4 cultures were positive for *L pneumophila*, serogroup 1. Of 549 *Legionella* Panels received, 11 had at least one positive reaction (Table 2). Six had a positive urinary antigen with negative DFA and culture, 3 had a positive DFA with negative culture and urinary antigen, and 2 had positive urinary antigen, DFA, and culture.

Discussion

The primary physician faced with a patient with either a community-acquired or nosocomial pneumonia should consider the possibility of *Legionella* infection. This is particularly true if the patient has one or more of the risk factors associated with this disease such as advanced age, cigarette smoking, chronic obstructive pulmonary disease, organ transplant, or immunosuppression.

Table 3. Diagnostic Tests for *Legionella* Infection

Time Required for Positive Results		
1 to 3 hours	3 to 7 days	3 to 7 weeks
Direct Fluorescent Antibody (DFA)	Culture on Selective Media (BCYE & BCYE-PAV)	Serology (IFA)
Urinary Antigen		
DNA Probe		
PCR		

Table 4. Specimen Requirements for *Legionella* Testing

Specimen	Applicable Test
Respiratory Secretions or Fresh or Frozen Lung	DFA Culture DNA Probe PCR
Urine	Urinary Antigen Detection
Single or Paired Sera	IFA

Laboratory methods available for the diagnosis of *Legionella* infections, with the corresponding time required for positive results, are shown in Table 3. Specimen requirements for these tests are listed in Table 4.

The most exciting and useful new test in the diagnosis of *Legionella* infections is the urinary antigen detection assay (Table 3). Our laboratory processed 1,519 urines by this rapid (1 to 3 hrs) and relatively inexpensive method. It appears to be exquisitely specific with a sensitivity rate of approximately 85% to 95%. Another advantage is that the urinary antigen remains positive throughout therapy. The major drawback of this assay, however, is the limitation to detecting only *L pneumophila*, serogroup 1, antigenuria. This is somewhat minimized by the fact that *L pneumophila*, serogroup 1, is responsible for the majority of all cases of *Legionella* infection.[12] In our "*Legionella* panel" series the urinary antigen was the most useful diagnostic test. The three cases of negative urinary antigen with positive DFA indicate infections produced by *L pneumophila* other than serogroup 1.

The DFA assay is a rapid test (1-3 hrs) for the detection of *L pneumophila*, which can be used on any respiratory specimen (Table 4). Monoclonal antibody-based reagents, specific for all serogroups of *L pneumophila*, has clearly reduced cross reactivity with other bacteria, a critical problem with currently available polyclonal immunofluorescent assays. In patients treated with appropriate antibiotics, *Legionella* may not be able to grow in sputum culture, but still the DFA may be positive. The three cases of positive DFA with negative culture in our "*Legionella* panel" may reflect prior use of antibiotics. Current data suggest a sensitivity rate of approximately 75% with the DFA reagent.[13]

Culture of clinical specimens for *Legionella* on selective media is considered the "gold standard," against which all other tests are compared. Culture will detect all *Legionella* species, not being limited to *L pneumophila*. Pulmonary infections caused by other species of *Legionella* produce a positive culture with a negative DFA and urinary antigen. The sensitivity of culture for *Legionella* is difficult to determine due to differences in specimen preparation, however it is generally considered to be approximately 70% to 80% sensitive.[15]

There are two other tests for rapid diagnosis of *Legionella* infections, one commercially available, the DNA probe assay, and one in the first stages of research, which employs the polymerase chain reaction.

The DNA probe assay for the detection of *Legionella* spp. is a commercial kit marketed by Gen Probe, Inc, San Diego, CA. It is a relatively easy kit to run and does offer detection at the genus level. However, with a radio-immunoassay (^{125}-I) format, one must have a gamma counter available. In addition, the cost of running this assay is substantially more expensive than a DFA, and does not offer a proportional increase in sensitivity (69.7%).[14]

The use of the polymerase chain reaction (PCR) for the detection of microorganisms is revolutionizing the field of infectious diseases. PCR is a nucleic acid amplification method, whereby within a matter of hours, as many as one million copies of a specific segment of DNA can be generated from a single target segment. This methodology has the potential to detect the presence of a single *Legionella* bacterium in a clinical specimen. Our laboratory is currently involved in PCR research in the area of *Legionella*, as well as *Mycoplasma pneumoniae*, and *Chlamydia pneumoniae*. We were able to demonstrate the presence of *Legionella* in throat swab, sputum, and bronchoalveolar lavage specimens using the PCR technique in several patients with Legionnaires' Disease. The capability of this technology to increase

the sensitivity of bacterial detection to extraordinary low levels is exciting.

In summary, the current recommended test for rapid diagnosis of *Legionella* infections is the "*Legionella* Panel" described above. This consists of a urine and respiratory specimen for urinary antigen, DFA, and culture. The urinary antigen detection is more likely to be positive in the presence of a negative DFA or culture, and will confirm serogroup 1 infection. A DFA will serve to identify infection by *L pneumophila*. Culture of the respiratory specimen on BCYE and BCYE-PAV will serve to detect non-*pneumophila* isolates. These isolates will produce a negative DFA and urinary antigen.

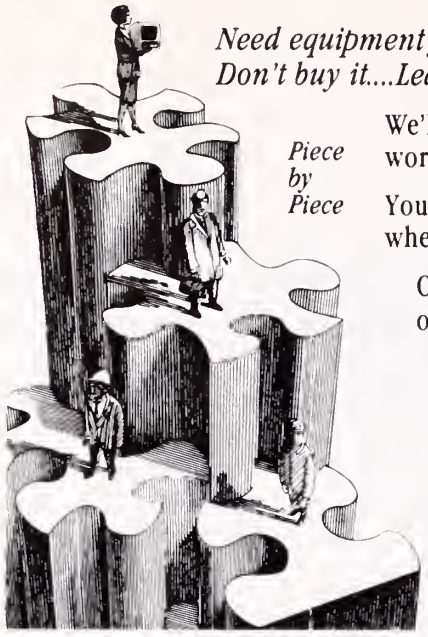
The use of a combination of methods, or "*Legionella* Panel," offers a rapid, sensitive, and specific way of diagnosis. The addition of PCR to current diagnostic tests will further improve our ability to recognize and treat patients with *Legionella* infections.

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Healthcare Reform

TO THE EDITOR: As the discussions go on about "Healthcare Reform," neither the lay press nor physicians have drawn attention to one important factor: Namely, the increase in insurance costs to cover unfunded Medicare obligations.

This concept was made concrete for me recently at the KMA meeting during sessions sponsored by the American College of Pulmonary Physicians. Information presented revealed that the DRG for congestive heart failure treatment paid in the range of $3,500 to $4,000, whereas the actual costs of treating congestive heart failure, averaged across the country, are in the eight to ten thousand dollar range.

The point is that little by little huge unfunded public obligations have been irresponsibly shifted onto the shoulders of working people.

Mr Clinton knows this; it is part of the sleight-of-hand of his healthcare bill that he will magnify this problem by shifting all responsibility of the uninsured onto the taxpayer, as has already been done with the public obligations to the elderly.

I do not believe it is to the credit of organized medicine, and I believe it reflects on the lack of confidence that the general public has in organized medicine, that we have failed to bring this matter to the forefront of discussions about how to reform healthcare.

How could we bring this problem to the public's attention? One proposal could be a bill to provide "truth in medical billing." This would require every hospital bill to provide for each patient information about what that patient's actual bill is in terms of the actual components of his medical care, as opposed to present billing practices which contain substantial cost shifting to cover losses from unfunded public obligations. For instance, a patient would receive a bill detailing specifically what their actual nursing care costs, what their actual medications cost, and administrative surcharge as well as a charge to cover malpractice insurance, etc, along side the usual hospital bill.

Patients would be able to understand, in this way, the magnitude of the burden that is being shifted from non-working people to working people; then we could begin to have a real dialogue in this country about what medical, legal, and administrative costs the public as a whole is willing to accept as appropriately charitable and what it will not accept as being excessive and luxurious.

It is my opinion that the only way to salvage this system is to decontrol the system, which is the opposite of what Mr Clinton is proposing. Abolish DRGs and let each person pay his or her fair share. Only in such a situation will we finally have to confront what proper role our charity will bear in this whole matter. The alternative is the virtual enslavement of the middle class of this country under a tremendous and inefficient healthcare burden.

F. Andrew Morfesis, MD

Tending to *Business*

TO THE EDITOR: Ages ago when I was a young, eager surgeon, but aware that I had a wife to care for as well as three children to educate, an older wiser physician told me two things which I took to heart and, along with other aphorisms he told me, tried to live by.

1. Take care of your patients and they will take care of you; (ie, the money will be there).
2. Don't worry about patients you don't have, take care of those you do have, and you will have more than you can handle.

Unfortunately, things have changed. It does no good to complain, to march, to write nasty letters. One cannot turn back the clock. To be a complete physician today, to care for our families, we must pay attention to business. One does not have to leave compassion behind; one does not have to blunt their scientific bent. One must add a third dimension — business sense.

Most insurance companies use the CPT Book — *Current Procedural Terminology*. This is compiled and published by the American Medical Association.

Most insurance companies, including Medicare, send out bulletins. In order to stay current, one must peruse these bulletins.

Only a small portion of the CPT book and any given bulletin is applicable to any physician. A knowledge of the CPT book that pertains to any one physician is obtainable in the time it takes to read the daily sports or financial page in your newspaper. The same can be said for the bulletins.

Ones rejection of these aids has to be on an emotional basis, not intellectual, and can therefore be called childish at best. "I don't like Medicare, so I won't let them help me."

Three examples:

1. A sarcastic, long letter from a surgeon, in practice for several years, complaining about various procedures not paid for in the global period. The use of modifier "79" would have insured their prompt payment. The lack of this rudimentary knowledge has caused him anguish, delay in receiving income, and valuable time of a great many people.
2. A phone call from a surgeon complaining of claim denials. The use of modifiers explained. His comments, "Do not have time for all

of that." "Sorry, I lost it." He said he was a fool, didn't deserve to make a living, and hung up.
3. Twenty claims received from a "consulting" claims adjustment service in Chicago. All very slick, polite, reasonable, and all asking for a "22" modifier. No way! But, many true errors. This, I respectfully suggest, is not the way to spend your money.

Spend a few minutes each day with your office staff with the CPT book open before you running down and coding what you have done. Read the appendices. Read the introduction to your specialty. Look over the bulletins that come. Index the appropriate parts referring to your practice. Be a business person for a period of each day. Surely, it will put a child through college!

The next 5 years are going to be revolutionary, trying, and very different. Intelligence, which all who read this have in good measure, patience, adaptability, and a spirit of cooperativeness are going to be needed. Emotionalism, rejection, and a refusal to face facts will be counter productive.

J.B. Holloway, MD

Kentucky Cancer Registry

TO THE EDITOR: Some years ago the state of Kentucky passed legislation mandating a Kentucky Cancer Registry. The initial results of this registry have been made available to the Cancer Committee at the Harlan Appalachian Regional Hospital. I have compared our local statistics with state statistics and SEER statistics obtained from the NCI. For example, in 1991, 64% of Harlan County's breast cancer patients were diagnosed either at the in situ or local stage. In 1992, 48.1% were diagnosed in these stages as compared to SEER statistics of 53% overall on a national basis.

I was favorably impressed by these numbers, and I thought about the factors that might have had an impact on this situation: (1) Historically many physicians in Harlan county have been associated with the Daniel Boone Clinic. The Daniel Boone Clinic has created an organizational basis for common efforts which would usually not be possible in a small hospital setting. In addition, the Daniel Boone Clinic has given this local group of physicians leverage and focus in dealing with the local hospital. The late Medical Director of the Daniel Boone Clinic, Dr James Hurlocker, in the late 80s, pushed aggressively to have all physicians, through standardized chart notations, encourage all the clinic's female patients to have regular mammography. Substantial progress was made along these lines. (2) Dr Hurlocker and the clinic made significant efforts in causing the hospital to maintain its mammography services at an exceptional level.

On my own part, I continue to try and develop a method to track genealogically breast cancer patients in relation to their relatives so as to provide a basis for more intensive cancer surveillance.

None of these efforts is "high tech." Such efforts typically go unnoticed in the press in contrast to glitzy press reviews of the establishment of particular transplantation services or clinics for specialized surgery, which while significant for individual patients with unusual problems would scarcely impact the health of the entire state.

These statistics bring us closer to defining what the goals of medical practice should be.

As an aside, I note the tremendously litigious climate in which we practice; indeed, in neighboring Bell County an eight million dollar law suit has potentially threatened the very existence of the Daniel Boone Clinic, which has had such a favorable impact on the health of the people of this area. I believe that this type of information not only must be brought to the attention of the public, but I believe it should be admissible in courts of law in an attempt to balance the public's interest against the interests of the individual tort.

F. Andrew Morfesis, MD

UVB Levels

TO THE EDITOR: The interesting observations about UVB levels made by Brett Coldiron, MD, are largely explained by a few astronomical facts.

First — The point of the sun's highest altitude will generally be the time of greatest UV radiation.

Second — The highest altitude of the sun rarely is the same as local noon. Because of time zones, what the clock says is often out of sync with where the sun is. At the longitude of Cincinnati, Lexington, Richmond, Corbin and points south, "local noon" (highest sun altitude) is at 12:38 PM EST. When we factor in *daylight* time also, "local noon" at those locations is at 1:38 PM in the summer months. Thus, 2 hours before and after highest sun altitude is 11:38 AM to 3:38 PM. To adjust for Louisville longitude, add about 10 minutes (ie, 11:50 AM to 3:50 PM).

Third — It is apparent from Dr Coldiron's observations that this is in fact the case. He uses zero-minute intervals (10:00-11:00, etc), which obscures the findings slightly, but

nonetheless shows that 12 to 4 gives the largest amount of radiation.

As an amateur astronomer, I have long given my patients advice to be most cautious from 12 to 4 PM, instead of the old 10-2 interval.

I would mention that this phenomenon occurs at the far-western portion of each time zone and this would *not* be correct for, say, Baltimore, or Newark or Boston, nor for that matter, Chicago.

Shirley L. Barron, MD
Richmond, KY

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E = Have you ever had a drink first thing in the morning (**eyeopener**)?

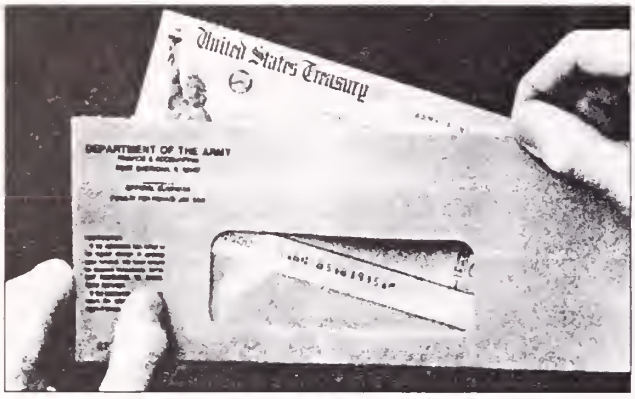
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While others were content to downplay the issue of family violence, Dr. Fullin would not. He petitioned state officials, and through his efforts the first Domestic Violence Advocate Program in his state was created.

"Organized medicine must serve as an advocate for patients," stressed Dr. Fullin.

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"Many of us remember the thrill, feet on the bottom rail and hands clutching the top of the fence, of the sound, the spray of steam droplets, and the majesty of speed and enormity of the modern, monster engines of 1936 trailing rocking, clacking cars punctuated by the ever red and never evolving caboose."

The railroad is the overland shipping miracle of the modern world. Its importance and capability tends to be overlooked because of its long establishment and the static presence it maintains in our exciting, glamorous world of increasingly rapid transit, personal and communicative. Many of us remember the thrill, feet on the bottom rail and hands clutching the top of the fence, of the sound, the spray of steam droplets, and the majesty of speed and enormity of the modern, monster engines of 1936 trailing rocking, clacking cars punctuated by the ever red and never evolving caboose. Having lived "on" and been comforted by the presence of these tracks for longer than 30 years, I eschew the *Wall Street Journal* imagining that the passage of frequent trains reports good times and few poor. It has pleased my sense of having a good friend close by that a train propelled by six diesel engines continues to have the charm, the bell, and the whistle of its steam ancestor.

Is the train safe? Just look at the statistics, wherever they are. My guess is that the 18-wheeler with its huge load of one and two trailers causes more death and incapacity.

When I cruise my county in my small Ford I am amazed at the number of railroad crossings I encounter. Many are guarded by gates. Others are guarded by pulsing red lights and many by nothing more than a road sign.

Now come the railroads volunteering to safeguard us the best they can by sounding a warning whistle at the crossing of each road. I can imagine a controversy in which a safety-conscious, apprehensive citizenry would request that the railroad sound a warning whistle at each road crossing. What I find incredible is that a population could object to the whistle and enact laws prohibiting our old and comfortable friend from trying to protect us.

A. Evan Overstreet, MD
Editor

...a promise to defend...

HERE ARE THE FACTS: Over 25% of America's Physicians were embroiled in a malpractice issue in the last 12 months. More than 80% of those malpractice allegations will be closed without an award for damages. Your professional reputation and your personal assets are on the line when your professional liability carrier is not both financially sound *and* experienced in the law and the judicial system.

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Improving the Image of Medicine: It's Not Just the Physician's Job



Gloria J. Griffin

Often the only contact the public believes it has with the medical profession is with their own physician. However, the image of medicine is the result of interaction with the public on many levels. A positive image of the medical profession is created each time you or your spouse participates in a community service activity.

It may come as no surprise that physicians' images are often the perception the public has about the physician's spouse. Our efforts need to be recognized as evidence of the depth of caring inherent in the medical family. Physician spouses in Kentucky care about the future of the citizens in our state. We are actively participating in our communities, helping the image of medicine each time we tutor the illiterate, deliver meals to the elderly, provide volunteer service in shelters, churches, schools and hospitals. Physician spouses across Kentucky are working in coalition with others to actively promote education about underage drinking, child abuse, family violence, teen pregnancy, drug and alcohol abuse, and smoking.

Together, our membership works for all of us — for our spouse, for organized medicine, and our communities. We are the best asset medicine has today. If you are not a member of the KMA Alliance, I would encourage you to join us to help improve the image of medicine; it's ONE CHOICE you can make for medicine now.

Information on becoming a member of the KMA Alliance is available to all physicians' spouses by contacting the KMA office:

Jean Wayne
KMA Alliance Executive Secretary
301 North Hurstbourne Pky,
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Gloria J. Griffin
KMAA President

"If you are not a member of the KMA Alliance, I would encourage you to join us to help improve the image of medicine; it's ONE CHOICE you can make for medicine now."





KMA Board of Trustees — December Meeting





Clackwise fram tap left: President Ardis D. Haven, MD, and Baard Chair Dan R. Stephens, MD (backs ta camera) presided aver the meeting; Immediate Past Board Chair Russell L. Travis, MD, staad ta address the graup; KMA Past President Danald C. Bartan, MD, presented a plaque ta autgaing Board member Harald C. Bushey, MD, in recagnitian af his many dedicated years af service; Baard Chair Stephens listened intently as President Haven emphasized a paint.

Convening in a regular session, the KMA Board of Trustees met on December 15-16, 1993. The Board members heard reports of the President; Secretary-Treasurer; Senior Delegate to AMA; Alliance President; President, Board of Medical Licensure; Dean, University of Louisville School of Medicine; Chair, KEMPAC Board of Directors; Chair, KMIC Board of Directors; and Commissioner for Health Services.

Detailed reports were given on the activities of the Committees on National and State Legislative Activities. The Board heard reports of the Chairs of the newly appointed Public Education Committee and the Physician Organization Study Committee, and adopted mission statements for both groups.

The Board members endorsed a "Nonhospital DNR Legislative Proposal" as outlined for introduction into the 1994 Kentucky General Assembly, and approved changes the Board of Medical Licensure was proposing to the Medical Practice Act. Approval was also given to proposed changes to the Hospital Medical Staff Section Bylaws, and action taken by the Executive Committee to implement directives of the 1993 House of Delegates was endorsed.

It was also agreed to allow the Kentucky Foundation for Medical Care to accept contributions for use by the Impaired Physicians Committee until tax exempt status for a separate foundation is granted by the IRS.

Appointments were made to the KMIC Board Election Nominating Committee, and selections were made for submission to the Governor for appointment to several boards and councils.

Legal Counsel provided an update on the state of KMA's lawsuit on the provider tax. A lengthy report was presented and discussion held concerning the AMA Nathan Davis Award, following which the Board voted to put this matter behind it and to direct the Association's full energies to the real crisis at hand — state and national health care reform.

Representatives of Kentucky Blue Cross and Blue Shield made a presentation regarding the KMA-endorsed BCBS plan for the membership. The next meeting of the Board was scheduled for April 13-14, 1994, at the Holiday Inn Hurstbourne in Louisville. KMA













Above from top: KMA Secretary-Treasurer William P. VonderHaar, MD, and Past President Preston P. Nunnelley, MD. Right from top: Alliance President Gloria Griffin; Chair, State Legislative Committee, Wally O. Montgomery, MD; Chair, KMIC Board of Directors, Richard F. Hench, MD; AMA Alternate Delegate J. Gregory Cooper, MD.

Report of the Committee to Investigate Changing Trends in Medicine

The following report was presented to the House of Delegates at the 1993 KMA Annual Meeting, and the House suggested that it be given prominent distribution through the KMA Journal. *It is felt that the entire membership should be made aware of its content.*

Because of the activity in Frankfort on health care reform this past year, the Trends Committee met one time. The charge to the Committee is to study and report on evolving delivery and payment mechanisms; to study and report on demographic trends affecting medical practice; to study and report on ethical questions regarding financial considerations versus quality of life; to investigate trends in cost containment activities; and to determine, to the extent feasible, the role of organized medicine in this changing environment.

Managed Care/Managed Competition

Managed care and managed competition are terms heard frequently today. Managed care refers to systems and techniques used by third-party payors to affect utilization and to control payment for health care services. Managed competition is a term given to a regulated free market approach to health insurance. It calls for individuals to buy health insurance as part of large groups organized by sponsors.

The structure of plans under the managed competition model varies considerably. Employer mandated coverage is common, though not universal. Government sponsors bring the uninsured, and in some cases small employers, into the system. Some proposals call for development of new information systems for assessing outcomes, provider performance, and cost/quality trade-offs.

Most managed competition plans are structured around "integrated systems" in which the administration, delivery, and financing of care are performed or managed by a single entity — or one with incentives to effectively direct patients through such entities. Integrated activities could be performed by insurers, insurer-provider partnerships, or health insurance purchasing cooperatives.

Physicians would be able to contract with whatever type of plan they felt to be most desirable or could form their own. However, it is likely that incentives and penalties would cause a shift in the distribution of coverage from traditional to HMO/PPO-type plans. Government regulations, based on current rhetoric, favor managed care plans.

Plans based on the managed competition model will rely heavily on managed care. Government and insurers are gradually shifting the financial risk of patient care to the provider community and those accepting — or having that risk forced upon them — will turn to managed care to assure dollars are spent as efficiently as possible.

While the concept of managed competition was developed by Enthoven in 1978, its recent acceptance as the health cost panacea has been extraordinary. Almost every state health reform effort embodies some elements of managed competition and it is expected that any national reform will be based on the concept. At the same time, the elements of managed care are becoming increasingly sophisticated and, if not more widely accepted among the physician community, are being more widely used.

The debate over managed care continues but there is some information that indicates that managed care is cost effective and medically efficacious. In a report published in the November 1992 issue of the *Archives of Internal Medicine,* Rapaport, Gehlbach, Lemeshow and Teres conducted an analysis of consecutive intensive care unit admissions at a regional tertiary care teaching hospital. Patients in managed care plans were compared with those covered by traditional insurance with respect to length of stay, hospital charges, charges for specific services, and the use of mechanical ventilation. The analysis controlled for severity of illness, case mix, and mortality. The sample cases examined represented medical care, emergency surgery, and elective surgery.

They found that the managed care group, on average, had shorter stays (both hospital and intensive care),

lower charges, and less use of mechanical ventilation than the traditionally insured group. The average differences were 30% to 40%. According to the report, differences were more pronounced in the patients with the lowest severity of illness.

The California Public Employee's Retirement System announced in February of 1993 that its members' premiums would rise by only 1.5% in 1993. The reason given for such a low increase was that the group demanded cost and performance data from providers in managed care programs and used collective purchasing techniques. However, critics said that the group sacrificed benefits while negotiating for savings and the lower premiums reflect reduced benefits.

Some say the savings from managed care plans such as HMOs and PPOs come from discounts on fees and hospital rates negotiated when the programs begin. Once accomplished, managed care plan costs and rates increase at about the same rate as traditional plans. In 1991, the Health Insurance Association of America, a trade group representing the for-profit insurance industry, surveyed over 3,000 US firms. It found that more than half (54%) of the employees in employer-sponsored health plans are now covered by managed care plans. Premiums in those plans increased 14% in 1991, showing identical increases for conventional, HMO, and preferred provider organization plans. HIAA concluded that despite increasing reliance on managed care, with more than half of covered workers now enrolled in HMOs, PPOs, or point-of-service plans, the cost of coverage continues to climb at the same rate as nonmanaged care plans. It is not clear if managed care costs increased along the lines of conventional insurance or if conventional insurance, reflecting a desire to compete with managed care plans and thereby contractually limiting the provider's ability to raise charges, followed managed care increases.

The AMA Council on Medical Service reported in December 1992, that over the period from 1988 to 1991, the average yearly cost increase was 18% for indemnity plans and 15% for HMOs. The report stated that, while not conclusive, the data suggests that after initial savings are achieved, managed care plans may not exert any greater financial restraint on rates of increase in spending than other financing systems.

A June 1992 report from the Congressional Budget Office reviews available studies and literature regarding the effects of managed care on the use and costs of health services. The report concluded that, "Managed care may also be less effective in controlling health care spending than the evidence from the 1970s and 1980s indicates, even for those organizations that are most tightly controlled. In the past, managed care has succeeded largely in reducing hospital use, but similar drops in the future are now less likely. Between 1980 and 1990, community hospital admissions per 1,000 population dropped nearly 14%. At the same time, the average length of stay per admission declined 5%.

"Hospital use has declined throughout the entire population; while those in HMOs use hospitals less, admissions and length of stay have also fallen among the population that is not enrolled in HMOs." The report continues: "Insofar as managed care's impact on spending is linked with its ability to reduce hospital admissions and length of stay, less hospital use means that HMOs will be able to squeeze less waste out of the health care system in the future. And the management techniques necessary to reduce the use of ambulatory care are relatively undeveloped."

Despite the lack of compelling evidence on managed care as a cost effective approach to medicine, it seems clear that government and the insurance industry are heading toward some form of a managed competition delivery system with an emphasis on managed care.

To discuss that movement, the Trends Committee was pleased to have several local individuals who are very knowledgeable about managed care meet with us and share their views regarding managed care and managed competition.

There was agreement among our guests that we are in the midst of a fundamental change in the delivery and financing of health care, and cost is the single driving force. The influence of providers on health care policy has diminished with the power shifting to business and government.

Payors are developing criteria to allow them to determine which providers are the most cost-efficient and will contract with them to provide services. As a result, the current trends toward group practice will accelerate. New structures will develop between physicians and hospitals. Integrated networks or accountable health plans will contract to deliver care to certain populations and share the financial risk. These plans will develop and use extensive data bases to assure that provider members are practicing in a cost-effective manner and to demonstrate the group's cost-effectiveness. The development and use of practice parameters and outcomes assessment will increase and will become more sophisticated.

Emphasis will be placed on preventive care with an emphasis on keeping people out of the hospital. Hospitals will be seen as cost centers instead of revenue centers. As a result, there could be a significant restructuring of hospitals with some changing their mission and others closing their doors. There will be a need to reorient society's thinking about the traditional role of a hospital. Some hospitals will assume a leadership role in creating these physician/hospital organizations, but their influence in the partnership is likely to diminish over time. Hospitals will provide management and financial services with physicians controlling the care. There will be financial incentives for early intervention because it can help control costs and produce better outcomes.

As stated earlier in this report, dis-

counts on fees haven't proven to be useful in restraining costs overall. Government and insurance companies will seek to transfer the financial risk of caring for insured groups to providers. This shift could be in the form of a capitated payment mechanism or through the implementation of global budgets. Physician/hospital integrated networks will negotiate with government and insurers, with contracts going to those entities that can demonstrate high quality, cost-effective care. To enable networks to negotiate under such a structure, Federal Trade Commission regulations will have to be modified and there is some feeling that Congress might authorize such a change in an overall reform package.

Large traditional carriers may serve as the catalyst for these changes. They already have massive amounts of data on provider performance and pricing. Provider profiling systems can review individual, group, and institutional efficiency. Carriers are more particular about providers accepted into their network. They no longer will accept a provider based on a willingness to contract with a carrier. Today, providers must demonstrate an ability to provide quality care in a cost-effective manner.

No one can be certain what format delivery and financing will take in the future. But clearly, the system is changing. The momentum to change has been building for over 20 years. Some form of a national health insurance seems imminent. National health insurance, which failed in the seventies because it was too expensive, is likely to be put into place today to control that expense.

The Trends Committee will continue to monitor this issue. At the time of our meeting in March, President Clinton had not reported his plan and Governor Jones had not called his Special Session on health care. As this report is being written 4 months later in June, President Clinton has postponed announcement of his reform plan and Kentucky has seen the appointment of yet another special task force on reform. Hopefully, major revisions in our delivery system will be phased in gradually with thoughtful consideration for the impact change will have on our patients. This country's delivery system evolved to its current structure over many years and may not withstand the trauma of instant reform.

I appreciate the active participation of the members of our Committee and the timely information shared by our guests.

Marjorie R. Fitzgerald, MD
Chair

RURAL KENTUCKY MEDICAL SCHOLARSHIP FUND

The Rural Kentucky Medical Scholarship Fund is accepting applications from residents of Kentucky, who have been accepted at the University of Kentucky College of Medicine or the University of Louisville Medical School. The Fund offers a $10,000 loan for each year of medical school to a qualified recipient who is willing to practice and reside in a rural county in Kentucky for one year for each loan received. The interest rate is determined on May 1. Repayment options include low interest rates for recipients practicing in rural areas and loan forgiveness for those practicing in areas of the state with critical needs. The Fund is the oldest and most successful of its kind in the nation. The Rural Kentucky Medical Scholarship Fund has loaned approximately $3 million to over 550 medical students. The deadline date for filing an application is **April 1.** Those interested in applying for a scholarship loan should contact the RKMSF Office at the Kentucky Medical Association Headquarters, 301 N Hurstbourne Parkway, Suite 200, Louisville, KY 40222, or call 502/426-6200.

PEOPLE

The AMA Board of Trustees recently reappointed KMA President **Ardis D. Hoven, MD,** to serve a 2-year term on the Advisory Committee on Group Practice Physicians.

Allan Tasman, MD, U of L department of psychiatry, is serving as president of two national professional organizations. They are the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry.

Stephen S. Kirzinger, MD, Louisville, raised more than $2,200 during a recent Multiple Sclerosis Benefit 150-Mile Bike Tour. The tour is an annual event to raise funds for the fight against MS. Dr Kirzinger, a neurologist, finished 35th in a field of 200 bikers and ranked among the top individual fund raisers.

Beverly M. Gaines, MD, was a recipient of the American Medical Women's Association Community Service Award at AMWA's 78th annual meeting in New York City. This honor came to Dr Gaines in recognition for her outstanding record of service during the past 17 years. AMWA is a national organization of more than 13,000 women physicians and medical students.

William B. Lockwood, MD, PhD, has been elected president of the Kentucky Association of Blood Banks. The KABB is a statewide professional organization whose 400 members include physicians, nurses, collection and distribution personnel, medical technologists, donor recruitment personnel, and administrators of blood collection centers and hospital transfusion services. Dr Lockwood is medical director of the American Red Cross Blood Services for the Louisville Region.

William G. Cheadle, MD, associate professor of surgery at the U of L School of Medicine, was one of the 10,000 athletes representing 60 countries at the 1993 World Masters Championships in Miyazaki, Japan. Dr Cheadle ran in the 400-meter flats and 400-meter hurdles, the last in which he won a gold with a time of 56.68 seconds.

In masters competition, men and women in age groups ranging from 35 to 90 compete in track and field events. The next World Masters Championships will be in Buffalo, NY, in 1995. Dr Cheadle continues to practice and plans to compete again in Buffalo.

Billy F. Andrews, MD, professor of pediatrics and chairman *emeritus*, University of Louisville School of Medicine, recently received The Winston Churchill Medal of the Wisdom Society for his contributions to medicine, education, and literature.

UPDATES

Public Education Committee

The newly appointed Public Education Committee held its first meeting on November 23, 1993, at the KMA Headquarters Office. The Committee is Chaired by Preston P. Nunnelley, MD, Lexington. The Committee consists of Harry W. Carloss, MD, Paducah; Gerald G. Edds, MD, Owensboro; Joseph E. Kutz, MD, Louisville; David C. Liebschutz, MD, Danville; Ross McHenry, MD, Edgewood; G. Irene Minor, MD, Berea; Paul R. Smith, MD, London; Jan Crase, Somerset, KMAA; and Ardis D. Hoven, MD, Lexington (ex-officio). The Committee reviewed various projects underway in other states and established a Mission Statement and goals the Committee expects to meet in designing public education programs to enhance the physician-patient relationship and overall improvement of the public's perception of physicians. The Committee is sending out a letter to all county society secretaries asking for assistance in various areas so that they can be attuned to local society needs. Cooperation with the Committee would be appreciated. Committee meetings will be held monthly, and if members have suggestions, please contact a member of the Committee or the KMA Headquarters Office.

KMA CME Accreditation Program Commended

The Accreditation Council on Continuing Medical Education (ACCME) recently awarded the Kentucky Medical Association's CME intrastate accreditation program continued recognition for a period of 4 years, its longest recognition period to date.

The ACCME commended the work of the Continuing Medical Education Committee and its Chair W. David Hager, MD, on its effort to maintain a quality accreditation program for the state of Kentucky. The ACCME additionally thanked the KMA for its efforts to provide excellence in CME programming for physicians in Kentucky through the accreditation of intrastate sponsors.

Committee on Impaired Physicians Needs Help

The work of the Committee on Impaired Physicians continues to expand. More and more hospital medical staffs, medical colleagues, other medical care workers and

family members have come to recognize the benefits of the Committee's work and to call on it for assistance. However, the work of the Committee can only be effective when reciprocal efforts are made by physicians. The Committee needs help to identify physicians with impairments, to participate in their aftercare, and to provide fraternal support to them and family members during the aftercare process.

The impaired physician presents difficulties that not only affect the entire medical community, but which require all physicians working together to help resolve. The benefits of these joint efforts are incalculable in terms of restoring our suffering colleagues to active, productive lives and the practice of medicine. The Committee stands ready to provide input and direct assistance and needs your help in identifying those areas where that assistance can be put to good use. If you have any questions or comments, please contact the Committee through the KMA office at 502/426-6200.

Unclogging Arteries

Wayne M. Shugoll, MD, U of L clinical assistant professor of medicine, has begun using a rotoblater to clean clogged arteries. The tiny device is inserted into the artery, where its diamond-tipped blades quickly spin through and clean out the blockage. Dr Shugoll says the procedure eliminates some complications, shortens recovery time, and decreases the likelihood of the blockage recurring.

Doctors Examine Literacy Problems

A new project titled "Progressive Pediatrics: Emphasis on Early Childhood Literacy" is underway at the University of Louisville. The most novel aspect of the project may be its venue: it's not operated by a school of education or an arts program but by medical clinics at the U of L School of Medicine.

"This is a project to bring medical and developmental issues together," said project leader and principal investigator **Veronnie F. Jones, MD,** assistant professor of pediatrics at the University Child Health Specialists (UCHS) clinic.

"We're trying to promote literacy as well as language, learning, and play skills, with the impetus being on the physician making an impact."

With 2-year funding from the Alliant Community Trust Fund, U of L pediatric residents working at UCHS and the Child and Youth Project are trained to promote reading by interacting with children and families while the children undergo medical exams.

The clients constitute two study groups: one receives both books and encouragement to read, the other receives just encouragement. The investigators want to see how parents and children follow through on these cues.

After the initial study, the project team intends to seek long-term funding to track the educational progress of the children throughout their school years.

Lung Association Cautions that Low-Tar and Nicotine Brands No Safer Than Other Cigarettes

The American Lung Association reports that, contrary to what many people may believe, the brand of cigarettes that smokers choose has little or nothing to do with their true exposure to tar and nicotine.

According to a study published by the American Lung Association, researchers who analyzed saliva and breath samples from 300 smokers found that subjects who smoked low-yield brands had carbon monoxide (CO) and cotinine levels that were barely distinguishable from smokers who used high-yield brands. Cotinine is a by-product of nicotine.

The Lung Association reports that these findings raise serious questions about the relevance of tar and nicotine data published by the Federal Trade Commission. These data are often cited in tobacco advertisements implying that there are health benefits associated with low-tar and -nicotine cigarettes. A recent Gallup survey, conducted for the American Lung Association, the American Heart Association, and the American Cancer Society, showed that most Americans interpret these ads to mean that low-yield brands are safer, less addictive, and healthier.

The American Lung Association of Kentucky is particularly concerned about the impact of these findings since our state has more smokers per capita than any other state and we lead the nation in smoking-attributable deaths. A report recently released by state health officials attributed one in every four deaths in Kentucky during 1991 to smoking, making smoking the number one cause of preventable death in Kentucky.

For information on Freedom From Smoking cessation clinics and self-help materials contact the American Lung Association of Kentucky at 1-800/366-LUNG.

Back Muscle Helping Heart Function Properly

According to a recent report from the University of Louisville, doctors will soon begin using patients' back muscles to stimulate their failing hearts.

The procedure, called cardiomyoplasty, involves wrapping the latissimus dorsi muscle around the heart, then training that muscle to work in rhythm with the heart.

U of L surgeon **A. David Slater, MD,** hopes to begin performing cardiomyoplasty in early 1994. He is only the sixth doctor to receive FDA approval for the surgery.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Boyd

Thomas H. Stanisic, MD — U
2301 Lexington Ave #130, Ashland 41101
1969, Northwestern U

Boyle

Roger J. Pentzien, MD — P
949 E Count Fleet Cir, Danville 40422
1974, U of Nebraska

Christian

Barbara J. Steed Newell, MD — FP
3601 Dale Hollow Rd, Hopkinsville 42240
1985, Medical Col of Ohio

Vicki Turnbough, MD — IM
Trover Clinic, Hopkinsville 42240
1990, U of Kentucky

Daviess

Michael J. Crowe, MD — D
1203 Center St, Owensboro 42303
1989, U Southern California

Randall E. King, MD — OBG
2504 Littlebrook Tr, Owensboro 42303
1989, U of Kentucky

Hopkins

Michael P. Fisher, DO — GE
200 Clinic Drive, Madisonville 42431
1984, Kirksville Col of Osteopathy

Jennifer Jackson, MD — FP
75 Shamrock Dr, Madisonville 42431
1981, U of Kentucky

Douglas J. Johnson, MD — FP
Trover Clinic, Morganfield 42437
1987, Washington U

Lawrence M. Kennedy, MD — FP
2913 Cox Mill Rd K-12, Hopkinsville 42240
1989, U of Louisville

Richard G. King, MD — FP
200 Clinic Dr, Madisonville 42431
1980, Duke U

Juan F. Rodriguez Acosta, MD — C
PO Box 370, Madisonville 42431
1983, U Puerto Rico

Jan E. Saunders, DO — ORS
200 Clinic Dr, Madisonville 42431
1987, Ohio U of Osteopathic Medicine

Jefferson

James R. Bosscher, MD — OBG
2 Woodlea, Louisville 40207
1979, Wayne State

Robert A. Campbell, II, MD — TS
6900 Fallen Leaf Cir, Louisville 40241
1985, U of Florida

Rama D. Chilukuri, MD — IM
1941 Bishop Ln, Louisville 40218
1986, Andhra U

Syam S. Chilujuri, MD — CRS
1169 Eastern Pky 3427, Louisville 40217
1987, U of Louisville

Jon W. Jones, MD — S
1530 Castlewood Ave, Louisville 40204
1986, Med Col of Georgia

Robert E. Murphy, MD — EM
1825 Hampden Ct, Louisville 40205
1990, U of Kentucky

Leigh Turner Price, MD — OBG
7638 Deer Meadow Dr, Louisville 40241
1989, U of Louisville

Sandra Y. Robles, MD — IM
9822 Third St Rd #110, Louisville 40272
1990, U of New Mexico

Michael Sagatelian, MD — GE
850 Washburn Ave #113, Louisville 40222
1986, U of California, Davis

Connie H. Shrake, MD — IM
558 Mallard Creek Rd, Louisville 40207
1990, U of Kentucky

Virginia R. Stokes, MD — GP
4703 Wolfcreek Pky, Louisville 40241
1981, U of Louisville

James D. Tutor, MD — PD
233 E Gray #201, Louisville 40202
1983, U of Mississippi

Lawrence

William Charles Thorndyke, MDCM — U
3 Rivers Med Pl #201, Louisa 41230
1978, McGill U

McCracken

James K. Ford, MD — C
PO Box 7648, Paducah 42002
1987, U of Louisville

Northern Kentucky

Barry L. Dick, MD — S
310 Terrace Ave, Cincinnati OH 45220
1983, U of Cincinnati

Pike

Larry W. West, MD — R
PO Box 2648, Pikeville 41502
1985, U Tennessee

Pulaski

Christopher J. Frost, MD — D
311 N Langdon St, Somerset 42501
1980, U of loa

Willie K. Wang, MD — AN
PO Box 3167, West Somerset 42564
1989, U of Mississippi

In-Training

Jefferson

William E. Lehmkuhler, MD — IM
Tarek Z. Mahdi, MD — FP
Rick McCombs, MD — IM
Julio E. Pabon, MD — OBG
Michael E. Rhodes, MD — AN

Trover Clinic

Ann L. Bradley, MD — FP
Gay Fulkerson, MD — FP
Ronald S. Ito, MD — FP
Joseph A. Milum, MD — FP
Susan J. Petrosky, MD — FP

DEATHS

Thomas E. Egan, MD
Covington
1932-1993

Thomas E. Egan, MD, a pulmonary disease physician, died November 10, 1993. Dr Egan was a 1958 graduate of the University of Cincinnati College of Medicine and was a member of KMA.

James E. Moore, MD
Ashland
1908-1993

James E. Moore, MD, a retired surgeon, died November 14, 1993. A 1934 graduate of the University of Louisville School of Medicine, Dr Moore was a life member of KMA.

William D. Hatfield, MD
Irvington
1920-1993

William D. Hatfield, MD, a retired general practitioner, died November 14, 1993. Dr Hatfield was a 1958 graduate of the University of Louisville School of Medicine and a life member of KMA.

Frank K. Sewell, Sr, MD
Mt. Sterling
1909-1993

Frank K. Sewell, Sr, MD, a retired family practitioner, died November 29, 1993. Dr Sewell was a 1933 graduate of Vanderbilt University School of Medicine and a life member of KMA.

Albert E. Leggett, Jr, MD
Louisville
1922-1993

Albert E. Leggett, Jr, MD, a retired ophthalmologist, died December 1, 1993. A 1945 graduate of Vanderbilt University School of Medicine, Dr Leggett was a life member of KMA.

Kenton D. Leatherman, MD
Louisville
1912-1994

Kenton D. Leatherman, MD, an orthopedic surgeon known worldwide for his treatment of spinal problems, died January 4, 1994. Dr Leatherman was especially prominent in treating scoliosis, and doctors from around the world studied under him over the years. He was a founding member and first president of the Louisville and Kentucky Orthopaedic societies, past president of the Scoliosis Research Society, and past director of the Scoliosis Clinic for Human Resources of Crippled Children Services of Kentucky. Dr Leatherman was a 1938 graduate of the University of Louisville School of Medicine and a life member of KMA.

THANK YOU!

The Kentucky Medical Association wishes to extend special recognition and appreciation to those 1993 KMA Annual Meeting exhibitors who so generously donated products from their booths to the Home of the Innocents, 485 E Gray St, Louisville, KY. Those exhibitors are:

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For Your Benefit

AMA to Congress: Doctors must make medical decisions in a reformed system

Physicians are "deeply concerned" the Clinton administration and others proposing health system reform would turn medical decision-making over to insurance companies and government bureaucrats.

In a Nov. 5 speech to the Commonwealth Club of California, AMA EVP James S. Todd, MD, expressed this concern, adding that reform will not succeed if doctors go from being patient advocates to simple allocators of services.

The speech, scheduled for broadcast through National Public Radio on 150 stations in 37 states, was the Association's first public address since President Clinton submitted his health system reform bill to Congress Oct. 27.

Applauding the Clintons for setting the stage for system reform, Dr. Todd turned comments toward Capitol Hill, saying the AMA will work hard to convince Congress to approve a bill that does not compromise patient care or the trust of the physician-patient relationship.

"It's time to set the rhetoric aside and start looking at what we have to work with, and decide exactly what it is we must have and what we don't need," Dr. Todd said. "The medical profession has definite views on how we think this process should unfold."

As the reform process turns to negotiations and compromise, Dr. Todd warned Congress that any plan calling for price controls, new layers of bureaucracy and overregulation will limit resources for patient care.

"Limits may be placed on the market forces that drive the kinds of vibrant competition we will need to sustain reform over a long period of time," he said.

Financing reform remains unclear, Dr. Todd said, adding any plan that relies heavily on Medicare and Medicaid cuts will threaten medical services for the poor and elderly "without providing the big bucks required to pay the bill."

He cited "the country's top economists," who warn that if anticipated savings fail to materialize," it will trigger deep reductions in medical services and destroy the promise of reform."

To find a "common ground" on reform, Dr. Todd said "it is essential that the discussion be constructive and nonpartisan and that all players work together to move the country toward consensus."

Prepared by the AMA Department of Communications Services. For information, call 800 AMA-3211, ext. 4416.

AMA supports senator's move to end violence against women

Calling for tougher measures to end violence against women, the AMA supported the "Violence Against Women Act of 1993" during congressional testimony.

"We view this act as a strong step forward in recognizing and treating domestic violence as the public health epidemic it truly is," said AMA President-elect Robert E. McAfee, MD, to the Senate Judiciary Committee Nov. 12.

The act, introduced by Sen. Joseph Biden (D, Del.), is consistent with the AMA's initiative.

The Association has declared violence as a major health issue and supports research, educational programs and appropriate interventions to increase public awareness of domestic and other types of violence.

"Not only does domestic violence add enormous unnecessary expenses to health care costs in the U.S., the human costs are especially tragic and immeasurable," Dr. McAfee said.

He commended Biden for introducing the act, which would establish federal penalties for sex crimes and provide extensive grant dollars to combat crimes against women, including measures to prevent crimes in national and public parks and on public transportation.

The bill also would establish a national commission on violence against women.

It also would provide assistance to victims, improve access to shelters, authorize funding for safer campuses and provide additional training and education for judges and court personnel.

The Association, Dr. McAfee told the Senate Judiciary Committee, is very active on issues of family violence and violence against women, including organizing a national 4,000-member coalition of physicians against violence.

The AMA also developed and distributed diagnostic and treatment guidelines on child physical abuse, child sexual abuse, domestic violence and elder abuse.

On March 11-13, 1994, the AMA will sponsor the National Conference on Family Violence: Health and Justice, in Washington, D.C. The conference will focus on how the health care and justice systems can work effectively together to address family violence.

Dr. McAfee said the AMA will "work closely with the committee to provide our expertise" on violence and to explain how practicing physicians can be major players in preventing violence against women.

AMA raises computer record confidentiality issues before Congress

Computerizing patient records raises serious security and confidentiality concerns, the AMA told a congressional panel, urging it to consider voluntary efforts already being pursued by the medical profession.

The AMA testified Nov. 4 before the House Government Operations Committee, which is investigating confidentiality issues tied to computerization of medical records.

AMA Trustee Donald T. Lewers, MD, expressed the Association's views on the subject, saying "critical issues of privacy and confidentiality" become increasingly important as use of computer-based medical records expands and gains greater attention under system reform.

"The AMA believes any recommendations that are ultimately formulated for computerizing patient records should combine technological and practical patient concerns," Dr. Lewers said.

He urged the panel to consider the "high costs associated with security systems" and ensure "that records be easily accessible by health professionals."

"The need to protect patient confidentiality, record security and integrity must be balanced with the practical constraints of achieving perfect security or confidentiality," Dr. Lewers said.

Prepared by the AMA Department of Communications Services. For information, call 800 AMA-3211, ext. 4416.

RATES AND DATA

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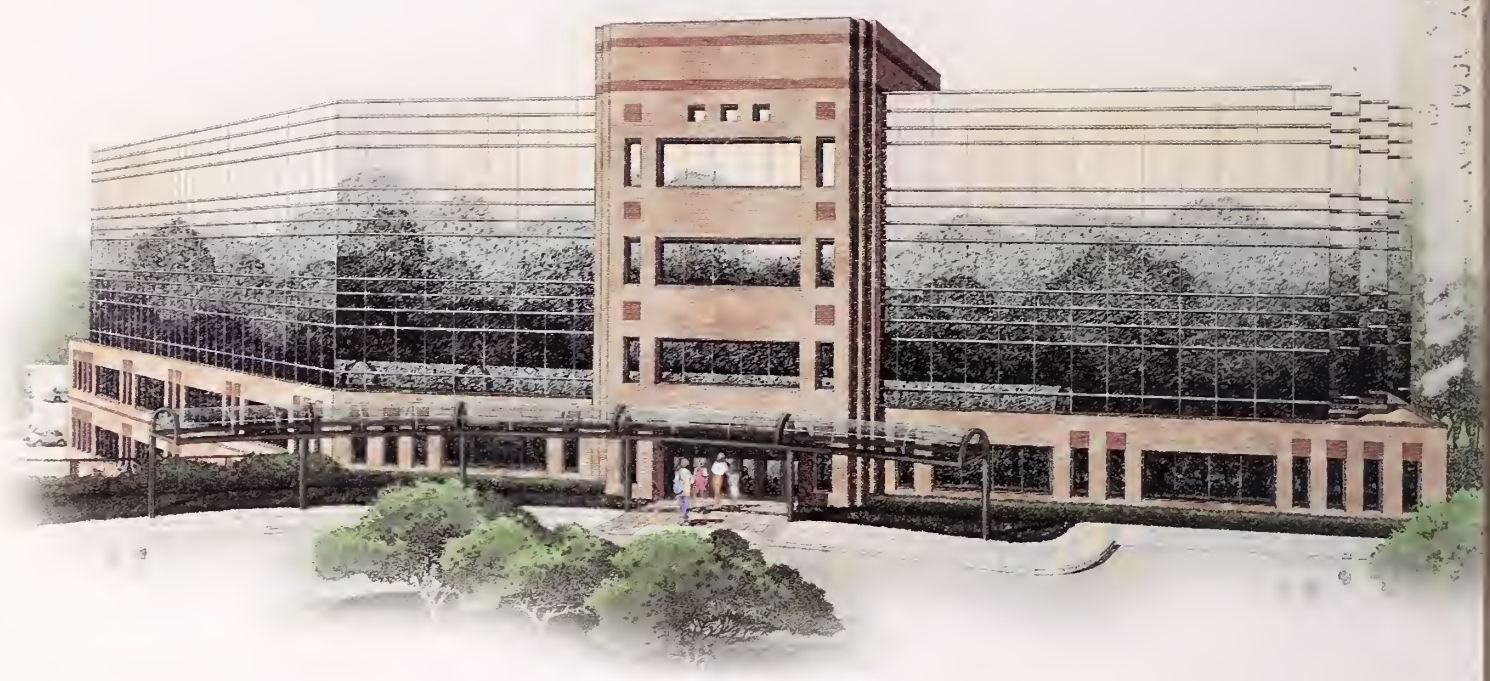
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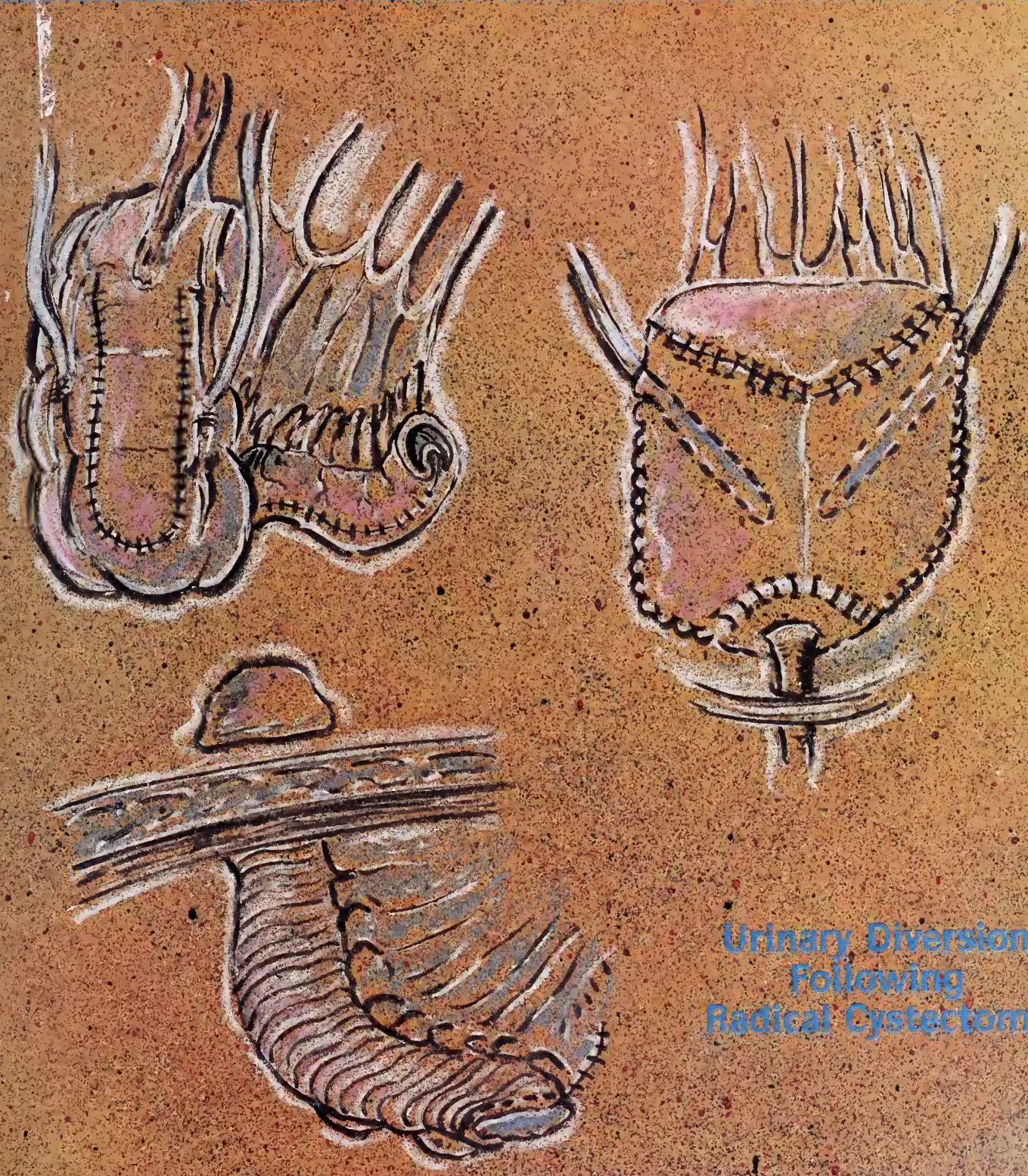
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Urinary Diversion Following Radical Cystectomy

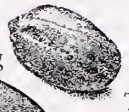
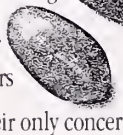
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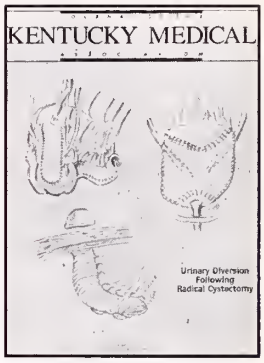


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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Second-class postage paid at Louisville, KY and additional offices. Yearly subscription rates: $25 domestic; $30 foreign. Single issues $3 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association,* 301 N Hurstbourne Pkwy, Suite 200, Louisville, KY 40222-8512. EDITORIAL AND ADVERTISING: Telephone 502/426-6200.

Listed in Index Medicus. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

National advertising representative: State Medical Journal Advertising Bureau, Inc, 11437 W 106th St, Overland Park, KS 66214, phone 800/788-2360.

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Hang Together — or Hang Separately?



Don R. Stephens, MD

Understanding politics and politicians is not an easy exercise for physicians. Politics is neither an exact science nor is it necessarily right or wrong. Politics, in its rawest form, is a merger of divergent views and interests — the art of compromise. Politics produces scoundrels — an occasional demagogue — but it also produces magnificent role models and true national heroes. Politicians generally react only to a crisis — going from apathy to panic — instantaneously. Understanding politics and politicians is an important primer for those who are interested in perpetuating a quality health care system.

In today's climate, where the public perceives that medical costs are too high and providers make too much money, physicians are sitting ducks for politicians looking for a target. Many elected officials view physicians as a group who look with a jaundiced eye upon politics. Elected officials, like it or not, believe that we show interest only when legislation affects our pocket books.

Dwight Eisenhower once noted that "the history of free people is never written by chance — but by choice — their choice." Kentucky physicians have a choice — or they can leave it to chance.

We cannot leave our fate to the public. The average Kentuckian is neither aware of nor involved in Frankfort's health system reform debate. Unless legislation calls for a tax increase or involves emotional issues like abortion, end of life measures, etc, the public remains aloof. Seven of eight Kentuckians have health insurance and most are relatively satisfied with their insurance cost and coverage. Their daily lives revolve around their jobs, the prices of groceries and gasoline; education of their children; winning lottery numbers; and last but not least, UK and UL basketball scores.

What about our internal politics? We have recently witnessed, both in Frankfort and Washington, segments of medicine jockeying for position — seeking advantages for themselves. We've watched representatives of some medical groups line up behind Clinton and Jones for photos. Sadly, the very issue that sparks public and governmental debate — economic and political power — divides us within. Will the body of medicine engage in internecine war over reimbursement and control of the patient? Does the history of socialized medicine in other nations where governments utilized the divide and conquer approach toward physicians and the use of "trust me" and outrageous promises teach us anything?

The late Tip O'Neil proclaimed "all politics is local." An analogy to O'Neil's point occurred when the Titanic struck an iceberg in 1912, sank, taking the lives of 1,500 to 2,200 passengers. The next day a Scottish newspaper led with the headline, "Aberdeen Man Lost at Sea." That's the way many physicians tend to react to the health care reform debate — not how it affects patients or even the profession — but how it affects me and mine.

We debate internally with growing hostility the issues of cognitive vs noncognitive services; surgical vs nonsurgical; urban vs rural; town vs gown; managed care vs fee for service. We can't even define or agree among ourselves on what specialties should be included under the "primary care provider" designation. Incidentally, this is an area where we might want to pay less attention to labels and more to function. Elected officials and government bureaucracy are aware of our internal dissension and eagerly perpetuate the differences. The Clinton plan has been characterized as "a system on a slippery slope to a

"Our choice is either "hang together or hang separately" — for that will be the price all of medicine will pay if we compromise and run for cover."

"Does the history of socialized medicine in other nations where governments utilized the divide and conquer approach toward physicians and the use of "trust me" and outrageous promises teach us anything?"

national health plan." The original Jones plan may have been even more draconian. Those within our ranks who rush to judgement and get on the bandwagon to seek advantage, play into the hands of our adversaries. They need to remember the old adage, "whatever hits the fan will not necessarily be evenly distributed."

The Clinton and Jones plans should serve to unify us. Don't our major objections to these plans cross specialty and geographical boundaries? Forced herding of patients into government determined collectives; restrictions placed on physician/patient relationships; freedom of choice eliminated; fee setting; provider taxes; super boards; independent practice of physician extenders; an all powerful Health Care Authority! These proposals should raise our indignation and create cohesiveness within the ranks. Our choice is either "hang together or hang separately" — for that will be the price all of medicine will pay if we compromise and run for cover. I am reminded of the biblical intonation "a house divided cannot stand" and our Commonwealth slogan "United we stand, divided we fall." Jim Todd, EVP of AMA, enlarged upon that theme before the AMA House of Delegates when he stated, "If we go forward in unity, the future is ours. If we retreat in disunity, the future is theirs. Whatever course we take, the decision is yours."

We must be cautious that John Locke's incantation "hell is truth seen too late" does not apply to us. 1994 may become judgement day for physicians. The debate in 1994 is likely to determine whether government or the private sector will prevail. This profession will continue to control its own destiny only to the extent that we as individuals, and collectively as a group, fulfill our professional, economic, and political obligations to our patients and our profession. In these perilous times we have a marked responsibility to our patients to participate in the public debate over the future of health system reform. For it is our patients who stand to lose the most — access to high quality medical care and freedom to choose their physician.

"1994 may become judgement day for physicians. The debate in 1994 is likely to determine whether government or the private sector will prevail."

If each of us participate in the ongoing debate — if we fulfill our obligations to society and the profession — we can prevail on behalf of our patients and the future of this profession.

Don R. Stephens, MD
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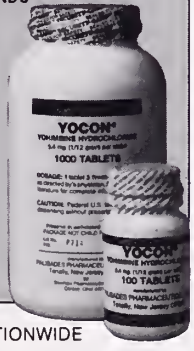
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1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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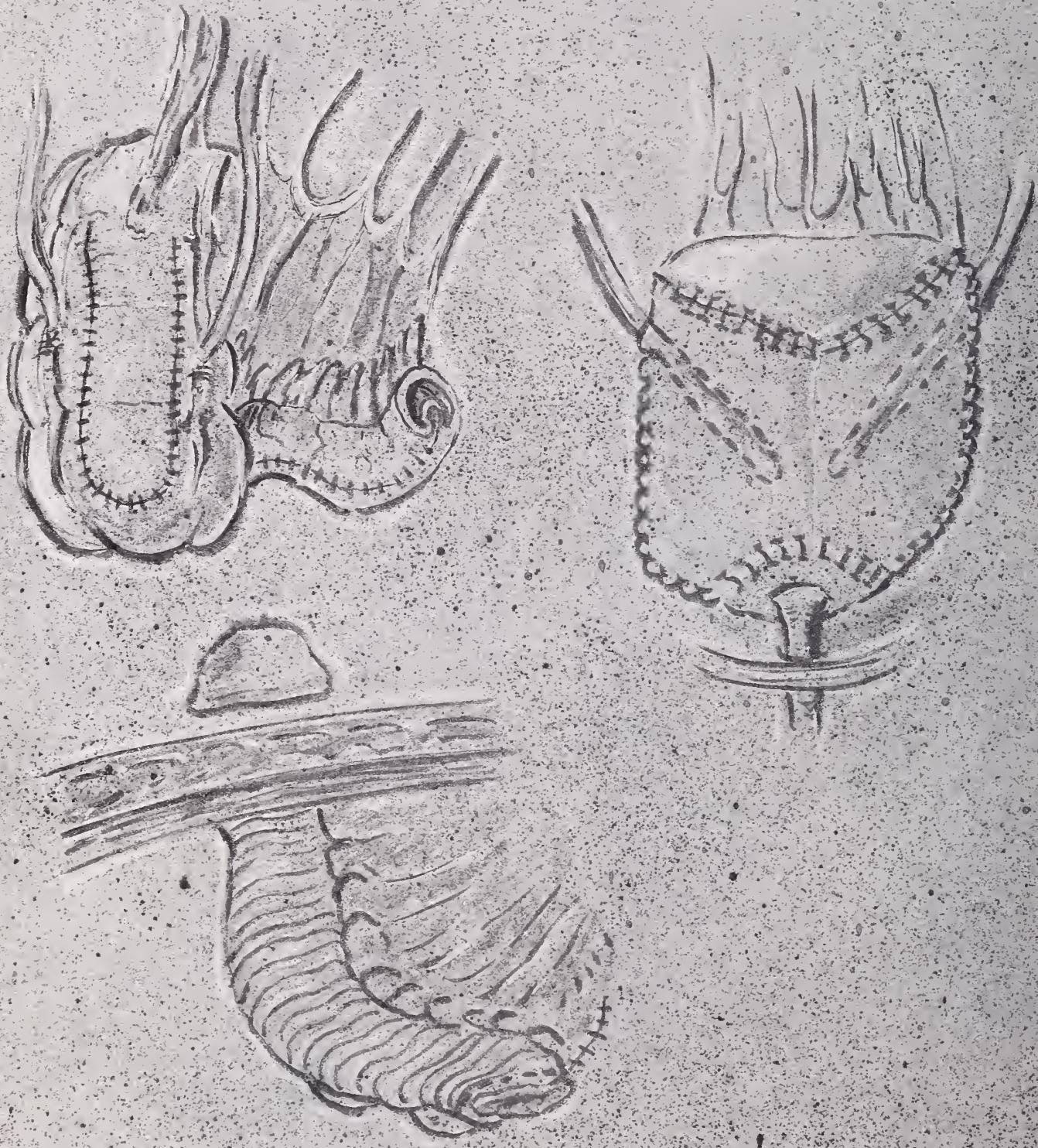
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Methods of Urinary Diversion Following Radical Cystectomy

David P. Wood, Jr, MD

This paper describes the three major types of urinary diversion and provides examples of the radical cystectomy patients who might be eligible for each. The ileal conduit is the simplest operative procedure to perform, but it requires the patient to perform a high degree of maintenance and has the greatest impact on self-image because of the need to wear a pouch. This technique is best suited for the medically ill patient at high risk for postoperative complications. The continent reservoir to the abdominal wall creates what is essentially a new bladder. The patient must catheterize the reservoir through a stoma at regular intervals, but no external pouch is required. A healthy patient of either sex is eligible for this procedure. The continent reservoir to the urethra restores nearly normal function. However, it adds several hours to the operative time, it has a somewhat higher rate of postoperative complications than do the other diversion techniques, and women are not eligible. Only highly motivated, healthy men are candidates for this procedure.

Over the last 10 to 20 years, surgeons have undertaken urinary diversion procedures for many reasons. Today, however, urinary diversion is indicated primarily following radical cystectomy for bladder cancer. From the urologist's point of view, removing the bladder successfully during the cystectomy is more challenging than creating a urinary diversion. From the patient's point of view, however, the urinary diversion is much more important, because the patient's satisfaction with the procedure generally depends on the type of diversion used. Therefore, to provide the best possible form of urinary diversion, the surgeon must consider the patient's medical condition, physique, and ability to deal with the consequences of the diversion. This report discusses the criteria for patient selection, advantages, and disadvantages of the three basic types of urinary diversion following radical cystectomy for bladder cancer.

From the Division of Urology, Department of Surgery, University of Kentucky Chondler Medicol Center, Lexington, KY.

Types of Urinary Diversion

Three basic types of urinary drainage are used following radical cystectomy for bladder cancer. These are an ileal conduit, a continent reservoir to the skin, and a continent reservoir to the urethra. Because each has its advantages and disadvantages, the needs of the individual patient should govern the type of diversion used. In making the choice, however, two basic principles should be observed. First, the cancer surgery must not be compromised. The physician's primary goal is to cure the patient, even if the cure involves a radical resection of tissue that would preclude a continent diversion. Second, performing a continent diversion must not increase the risk of operative mortality. A patient in poor medical condition is not a candidate for a long, taxing operation. Instead, the safest and shortest procedure should be performed.

These caveats, however, do not mean that we as physicians should always settle for the ileal conduit. After an ileal conduit, the patient must deal with an external reservoir, and the negative impact of this "bag" on a patient's self-image may be greater than we had previously thought.[1] It is primarily because they offer an alternative to the bag that continent urinary reservoirs have become popular.

Ileal Conduit

First described by Bricker in 1951, the ileal conduit is the "gold standard" of urinary diversion.[2] It is the most common type of urinary drainage system and has the least potential for problems after surgery. The conduit courses through the

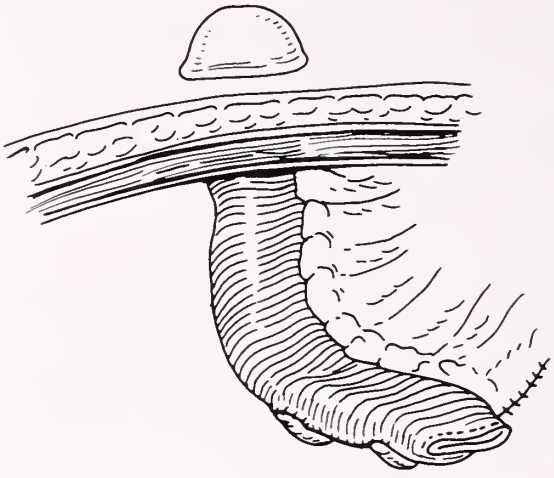


Fig 1 — Ileal Conduit.

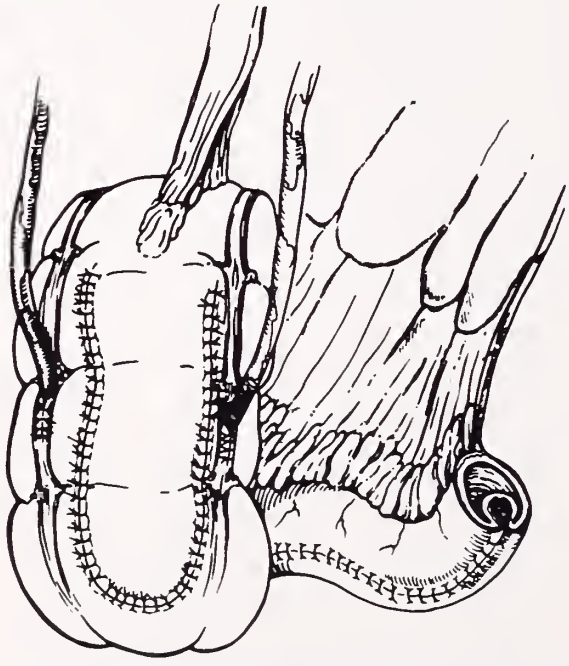


Fig 2 — Ileocecal pouch. Note the detubularization of the colon and the plicated segment of the attached terminal ileal.

abdominal wall, and a stoma is made on the abdominal skin (Fig 1). Urine drains constantly into a pouch worn over the stoma. The patient must empty the pouch every 3 to 4 hours, but with improvements in enterostomal therapy, the pouch plate need be changed only every 5 to 7 days. If the patient cleans the peristomal skin well, significant long-term complications are rare.[3] Odor is seldom a problem, the patient stays dry, and the pouch can be concealed underneath the clothing most of the time. Although many patients feel self-conscious wearing a bathing suit or otherwise exposing their stoma in public, they can participate in most physical activities.

An ileal conduit is clearly the best form of urinary diversion for the medically ill patient at high risk for complication following radical cystectomy.[4] Surgeons have had many years of experience in performing this procedure, and it is known to yield good long-term results with few perioperative complications in adults. The need to wear a bag, however, can affect the patient's life both psychologically and physically. Cystectomy patients now live longer and more actively, and they are requesting alternative forms of urinary diversion that will provide them with an improved quality of life.

Continent Reservoir to the Abdominal Wall

A continent reservoir to the abdominal wall is constructed from the terminal ileum and ascending colon, creating what is essentially a new bladder. This bladder holds the urine until it is emptied by intermittent catheterization. Although a stoma is created on the abdominal wall, it is flush with the skin and there is no need to wear a bag. Types of continent urinary reservoirs to the abdominal wall include the Koch pouch, Mainz pouch, and ileocecal pouch.[5] The ileocecal pouch is the first choice for a cutaneous reservoir if the patient's terminal ileum and ascending colon are intact.

The procedure has been described in detail elsewhere.[6] Briefly, the terminal ileum and ascending colon are mobilized, and the ascending colon is opened on its antimesenteric border and folded over in a Heineke-Mikulicz reconfiguration (Fig 2). The key to the operation is to produce a low-pressure reservoir. The intraluminal pressure must not exceed 30 cm H_2O when the pouch is full. A low-pressure reservoir is achieved by detubularization of the ascending colon to prevent the formation of a coordinated contraction that can increase the intraluminal pressure. The continence mechanism is fashioned by plicating the terminal ileum over a 12-French catheter with staples. The ureters are placed into the reservoir using a LeDuc anastomosis.[7] Performing the ileocecal reservoir usually adds 2 hours to the length of the operation, but a properly selected

patient will be able to tolerate the increased stress.

To empty the urine, the patient must catheterize the stoma every 4 to 6 hours. The pouch must be emptied regularly, otherwise mucus build-up can lead to obstruction. Between catheterizations, an adhesive bandage is worn over the stoma. Almost all patients are dry all day and all night, but approximately 5% to 10% will need a repeat operation to correct incontinence.[8] The repeat operation generally requires re-plication of the terminal ileum to tighten the continence mechanism.

The continent reservoir to the abdominal wall requires no bag, and the pouch will not be obstructed by a local recurrence of the tumor in the urethra or pelvis. Nevertheless, a stoma is still present, and the patient must catheterize it at regular intervals. The continent reservoir to the abdominal wall is ideally suited for men at risk for tumor recurrence in the urethra or for women who need a total cystectomy.

Continent Reservoir to the Urethra

A continent reservoir to the urethra is the ideal form of urinary diversion to preserve quality of life. No stoma is required; the patient can void almost normally, and no one need know that the patient has an "artificial bladder." However, this procedure is appropriate only for highly motivated men willing to tolerate a complication rate that is slightly higher than that for other diversions. Women are not eligible for this form of urinary reservoir because their main continence mechanism is the bladder neck. When a radical cystectomy is performed on a woman, the entire bladder and urethra are removed. When a radical cystectomy is performed on a man, however, the membranous urethra is left intact. Consequently, the continence mechanism remains as functional as it does after a radical prostatectomy.

Candidates for this urinary diversion include only men at a very low risk of a urethral recurrence, that is, those with solitary bladder tumors well away from the bladder neck or trigone and without evidence of carcinoma in situ.[9] A patient whose tumor extends into the bladder neck or prostatic urethra is at high risk for a urethral recurrence.

Candidates for a continent reservoir to the urethra must be highly motivated and willing to tolerate a period of incontinence similar to that following radical prostatectomy. Some type of incontinence, mainly at night, will be experienced by approximately 3% to 5% of patients undergoing this diversion.[10] A large amount of postvoid urine can build up because the ileum does not empty completely during abdominal voiding, and experience has shown that patients may need to perform intermittent catheterizations to completely empty the pouch.

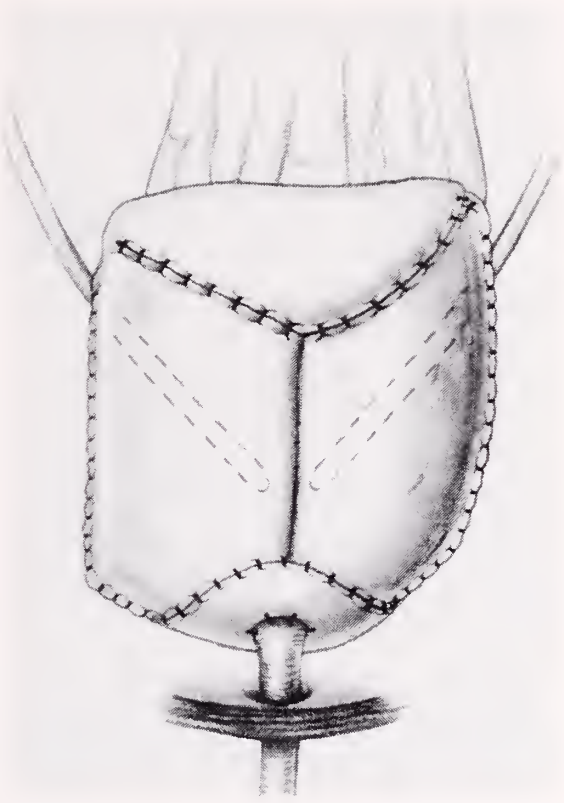


Fig 3 — Ileo-neobladder attached to the urethra. (Reproduced with permission from: Urologic Clinics of North America, 18(3): 558. 1991.[11])

Urinary reservoirs to the urethra have been fashioned in several forms; the ileal neobladder popularized by Dr Hauptman, for example, is a very reliable procedure.[10] Briefly, 70 cm of ileum is opened on the antimesenteric border. The bottom plate is sewn together with interrupted absorbable sutures, and the leading ileal segment is sutured to the urethra. The pouch is closed by rotating its lateral edges anteriorly (Fig 3). The ureteral anastomoses are made in the LeDuc fashion.[7] A cystogram is performed 3 weeks postoperatively to check for urinary extravasation. If no

urinary leakage is found, the urethral catheter is removed.

Conclusion

We as physicians must remember that patients will have to deal with their urinary diversions for the rest of their lives. They will not remember how well the operation went or the smoothness of their postoperative stay. Instead, patients will judge the success of their surgery by the ease with which they can take care of their urinary diversions. Therefore, we must be attuned not only to the patients' medical conditions but also to their lifestyles. As we gain more experience, the complication rate for continent urinary reservoirs is decreasing dramatically and, therefore, patient acceptance is improving. For properly selected patients, a continent reservoir will improve self-esteem and quality of life without compromising the cancer surgery.

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Abnormal Pulmonary Function and Juvenile Onset Diabetes Mellitus

Stephanie Walton, MD; Ryland P. Byrd, Jr, MD; Cheryl L. Fields, MD; Miguel A. Ossorio, MD; Thomas M. Roy, MD

The metabolic and microcirculatory abnormalities associated with insulin-dependent diabetes mellitus involve most organ systems, including the lung. The adverse effects of diabetes mellitus on the function of the respiratory system are minor compared to the morbidity sustained by the cardiovascular, renal, neural, and ophthalmic systems. Nevertheless, physicians should be aware that some indices of pulmonary function may be abnormal in diabetic patients, independent of the more commonly recognized respiratory risk factors.

The metabolic changes associated with insulin-dependent diabetes mellitus may cause structural and functional changes in human nerves, vasculature, and connective tissue.[1] Since the architecture of the lung consists primarily of capillaries, alveoli, and connective tissue, it might be expected that insulin-dependent diabetes mellitus should cause pulmonary abnormalities.

In 1976, the first observation of a restrictive respiratory defect was reported in a subset of insulin-dependent diabetic patients who also had palpable skin induration and limited joint mobility.[2] Initially, this pulmonary function abnormality was ascribed to a decreased compliance of the skin and chest wall.[3] Subsequent investigators, however, have shown that lung volumes are reduced in a restrictive pattern in insulin-dependent nonsmoking patients who do not have limited joint mobility.[4]

We present a patient with juvenile onset diabetes mellitus who was referred for evaluation of a restrictive defect discovered on pulmonary function testing. A review of the possible effects of diabetes mellitus on commonly performed pulmonary function tests is provided for the clinician.

Case Report

The patient, a 22-year-old black female, was referred for further evaluation of abnormal pulmonary function tests (Table 1). She had been an insulin-dependent diabetic since she was 7 years old. She had achieved reasonable control of her serum glucose with twice daily insulin administration titrated against home glucose monitoring. Although she was shown to have a right carpal tunnel syndrome, she had not shown evidence of retinopathy, nephropathy, automonic neuropathy, or peripheral neuropathy. She had never used tobacco and lacked any significant recreational or industrial exposure to lung toxins.

Her vital signs were normal with the exception of a mild tachycardia of 120 BPM. Respiratory rate and pattern were normal. The patient weighed 120 lbs. The remainder of her physical examination was normal with particular emphasis on the cardiopulmonary systems.

In an effort to determine the etiology of her moderate restrictive disease and diminished diffusion capacity for carbon monoxide, additional

Table 1. Pulmonary function in a 22-year-old female with diabetes mellitus.

Test	Percent of Predicted
Forced Vital Capacity	51%
Forced Expiratory Volume in 1 second	57%
FEV1/FVC Ratio	89%
Total Lung Capacity	55%
DLCO	65%
PaO_2	86.5 mm Hg
A-a gradient	16.0 mm Hg

From the Division of Respirotory ond Environmentol Medicine, University of Louisville School of Medicine, 530 S Jockson St ACB-3, Louisville, KY 40202.

Table 2. Possible explonotions far decreosed elastic recail in potients with diabetes mellitus.

Reduction in pulmonory copillory blaad valume.
Increased olveolor size (without porenchymal destruction) becouse of interference with lung develapment.
Glycasalatian-induced functianal alteratians in the connective tissue af the lungs.
Alterotion of surfactant by chranic hyperglycemio.
Destruction of lung porenchyma with accelerated oging.

tests were requested. A serum survey to detect collagen vascular or rheumatologic disorders was normal. Thyroid functions were also normal. Her electrocardiogram confirmed a mild tachycardia but was otherwise unremarkable, with a normal ventricular axis and no suggestion of ischemia, infarction, or conduction delay. An echocardiogram confirmed normal chamber sizes, normal valvular structure, and normal ventricular function. Chest film was interpreted as free of active disease. A gallium scan failed to show any evidence of alveolitis or pneumonitis. Evaluation of diaphragmatic function under fluoroscopy was normal.

Yearly monitoring of this patient's pulmonary function will continue, but it is felt that her measured abnormalities are consistent with the metabolic effects of insulin-dependent diabetes on the lung.

Discussion

Physicians in all disciplines participate in the care of patients with diabetes mellitus. As more physicians incorporate spirometry into their routine office assessment, they may be challenged with the explanation of apparent pulmonary impairment in the patient with juvenile onset diabetes mellitus.

Approximately 73% of young, nonsmoking, insulin-dependent diabetics are expected to have abnormalities in either lung mechanics and/or gas exchange.[5] Two predominant patterns of lung dysfunction are cited and are observed to occur alone and in combination. These are a decrease in lung volumes in a restrictive pattern and a reduction in the carbon monoxide transfer across alveolar capillary membranes. The actual prevalence of each type of variant is unknown because of inconsistencies between studies that are introduced by differences in the populations studied in terms of race, age, gender, smoking history, and variation in measurement techniques.

Reduced elastic recoil at low lung volumes that is associated with low FEV1, FVC, and total lung capacity[2] is the most frequent abnormality reported. Smaller than predicted lung volumes were first documented in a subset of juvenile onset diabetics with a disorder termed limited joint mobility.[3] Later investigators found similar limitation in elastic recoil with diminished total lung capacity (TLC) in diabetic children and young adults without limited joint mobility.[2,3,4,6]

When 375 diabetic children were evaluated, 19% of the patients had a vital capacity that was significantly lower than their predicted value based on their height, gender, and ethnic background. Interestingly, female patients appear to experience a higher incidence of low vital capacities than males ($p < 0.001$). The volume changes could not be associated with the patient's age, ethnic background, duration of diabetes, insulin dosage, skin changes, limitation of joint mobility, retinopathy, or proteinuria.[4]

There have been a variety of hypotheses offered to explain the increased chest wall stiffness (Table 2). Chest radiographs are normal. Although some centrilobular emphysema has been reported on autopsy of nonsmoking patients with diabetes mellitus,[7] it is generally concluded that there is not sufficient parenchymal lung destruction to significantly affect elastic recoil.

Qualitative changes in alveolar surfactant have been detected in diabetic animals and could possibly contribute to a loss of elastic recoil.[10] The lack of complete surface-tension effects of this phospholipid is thought to be related in some way to chronic hyperglycemia. This postulate has not been adequately explored in humans and does not fit well with the observation of restrictive defects in young patients with relatively good glucose control.

The most plausible explanation involves an abnormality in collagen systhesis and cross-linking and can also be supported by histologic examination of lung matrix. Collagen, the most abundant protein in the human lung, is critical to its structure and function. There is a network of cross-linked collagen in an elastic matrix conferring elasticity to the lung parenchyma. Lung stiffness is augmented by a net increase in the number of collagen cross-links, a feature consistently found in experimental diabetes.[8] This phenomenon is thought to occur secondary to increased glycosolation of collagen.[9] This nonenzymatic gly-

cosolation of connective tissue interferes with normal molecular cross-linking, changes the mechanical properties of the lung's connective tissue, and results in increased elastic recoil with decreased chest compliance.

The second most commonly noted respiratory abnormality in insulin-dependent diabetics is a decrease in the diffusion of carbon monoxide. Two structural abnormalities may be operative. Human autopsy findings in the lungs of diabetic subjects include thickening of the basal laminae of the alveoli[11] and diabetic microangiopathy in the capillaries of alveolar septa. The etiology for the thickened alveolar interstitium is postulated to be enzymatic, a reflection of increased lysyl oxidase activity, and basal lamina thickening is considered the initial lesion in the development of diabetic microangiopathy.[7]

As in nondiabetic individuals, impairment of gas diffusion across the alveolar-capillary interface is usually multifactorial. The lower mean DLCO in diabetic patients is attributed primarily to a lower pulmonary capillary blood volume and secondarily to a physical barrier to normal membrane diffusing capacity. These changes may be accented by an increased concentration of glycosolated hemoglobin that can lengthen CO-hemoglobin reaction time. Even though hemoglobin glycosolation may effect CO transfer to a minimal degree, no strong correlation can be established between HbA1C measurements and DLCO when measured at rest.

It has been impossible to establish a definite relation of lung changes to other diabetic complications. This becomes apparent when we recognize that respiratory changes can be documented in insulin dependent diabetics who are young and free of the severe end-organ changes such as diabetic neuropathy and microvascular damage. In most studies to date, there has been no difference in age, duration of diabetes, and level of control (HbA1C) between those patients with and without abnormal pulmonary function.

Interestingly, in one study, the mean duration of diabetes in patients with abnormal lung function was only 4.7 years. The authors suggest that pulmonary dysfunction, if present, may be the earliest measurable nonmetabolic alteration in insulin-dependent diabetic patients.[5] A longitudinal study to identify a temporal relationship of lung involvement and other diabetic end-organ involvement has not yet been performed.

Despite our ability to predict physiologic changes based on histologic observations, we are unable to predict the pattern of pulmonary dysfunction or which insulin-dependent diabetics will be affected. A few small studies fail to find detectable abnormalities in diffusion or lung volumes in the diabetic population,[12,13] documenting that some insulin-dependent diabetics escape respiratory damage.

There are several explanations for the discrepancy between studies. First, the pulmonary function changes that occur among normal individuals are often wide enough to mask mild differences between patients and controls, particularly when small numbers are studied. Second, a random pattern of organ involvement is a well acknowledged feature of diabetes mellitus. It has been suggested that the diabetic population with respiratory abnormalities may have sustained a single acute episode of nonprogressive damage to lung growth during the early months of development. Finally, might the reduction in lung volume in insulin-dependent diabetes be the result of a genetic factor? This genome, involving an abnormality of collagen structure, would be linked to the predisposition for diabetes, but have variable penetrance.[6]

Regardless of the causative features, clinical experience suggests that the pulmonary defects in insulin-dependent diabetics are usually mild and do not cause significant respiratory embarrassment without other risk factors. Since it is established that tobacco use is associated with an increased frequency of retinopathy and nephropathy in diabetic patients, it is tempting to suggest that the effects of cigarette smoking and diabetes mellitus may be synergistic in damaging the pulmonary microvasculature.[14]

The general consensus is that the majority of a diabetic population will have abnormal pulmonary function in the form of a mild restrictive defect due to a reduction of elastic recoil and/or a reduction in pulmonary diffusion capacity of carbon monoxide (DLCO/VA) because of a reduced pulmonary capillary blood volume. Overall, the clinical implications of the dysfunction of lung mechanisms and CO diffusion remain uncertain. It would appear they could be of clinical importance if the patient becomes a cigarette smoker or is subjected to an unnecessary workup to eliminate other causes of these abnormalities.

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TO HELP OTHERS
WE MUST HELP EACH OTHER

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Fish Oil (ω-3 Fatty Acids) in Treatment of Hypertriglyceridemia

A Practical Approach for the Primary Care Physician

Harold Bays, MD; Allan M. Lansing, MD, PhD

Omega-3 fatty acids, found commercially in fish oil concentrate, may be a useful and safe treatment in lowering elevated triglyceride blood levels. A case is presented of a severely hypertriglyceridemic patient with an idiopathic adverse reaction to gemfibrozil and clofibrate who demonstrated a significant response with fish oil therapy. The benefits and risks of fish oil treatment are discussed.

Case Report

Prior to presentation at our clinic, a 66-year-old white female with severe combined hyperlipidemia, but without known atherosclerotic coronary artery disease (ASCAD), had been treated with triple lipid-acting drug therapy that included niacin (500 mg twice a day), lovastatin (40 mg once a day), and gemfibrozil (600 mg twice a day). The addition of gemfibrozil to the treatment regimen resulted in gastrointestinal distention, severe body and facial angioedema, and was subsequently discontinued. Severe hypertriglyceridemia recurred and clofibrate was attempted. But the patient again experienced marked angioedema and erythema of the face and gastrointestinal distension. She was then evaluated at our clinic for further evaluation and treatment.

Initial fasting lipid blood levels (while taking lovastatin, niacin, and clofibrate) included total cholesterol 319 mg/dl, triglycerides 906 mg/dl, and high density lipoprotein (HDL) cholesterol 53 mg/dl. Because of the severity of her angioedema and gastrointestinal distention, all lipid-lowering drugs were discontinued. The erythema, angioedema, and gastrointestinal distention gradually resolved. Repeat blood testing 1 month later revealed total cholesterol 540 mg/dl, triglycerides 2010 mg/dl, and HDL cholesterol blood level of 55 mg/dl. Lovastatin (20 mg bid) and niacin (1000 mg bid) were gradually reinstituted without recurrence of the before-mentioned side effects. However, dyslipidemia persisted with total cholesterol 385 mg/dl, triglyceride 1190 mg/dl, and HDL cholesterol 50 mg/dl.

Because of the severe hypertriglyceridemia, risk for acute pancreatitis, and previous drug allergy to fibrates, fish oil therapy was initiated with cholesterol-free 1000 mg fish oil concentrate, 2 gel capsules three times a day with meals. She had substantial improvement with her most recent total cholesterol 276 mg/dl, triglycerides 529 mg/dl, and HDL cholesterol blood level of 42 mg/dl.

Discussion

Omega-3 fatty acids are polyunsaturated fatty acids abundant in cold-water marine fish oils such as mackerel, herring, sardines, and salmon. The omega-3 fatty acids eicosapentanoic acid (EPA) and docosahexanoic acid (DHA) found in these marine fish oils have been shown to reduce very-low-density lipoprotein (VLDL) synthesis in the liver with reduction in triglyceride blood levels.[1] A concomitant rise in low-density lipoprotein (LDL) cholesterol and HDL cholesterol blood levels is often noted. Although some investigators believe the increase in LDL cholesterol may not be clinically adverse because of favorable altered lipoprotein configuration produced by these fatty acids,[1] this has yet to be confirmed by clinical trials. Therefore, additional lipid-lowering drugs may be required to lower the increased LDL cholesterol blood levels.

Many studies have suggested that hypertriglyceridemia is an independent risk factor for

Dr Boys is Medical Director of The Lipid Center, Audubon Hospital, ond Dr Lonsing is Director of Audubon Heart Institute Internationol, Auduban Hospital, Louisville, KY.

Reprint requests to Auduban Heart Institute Internotionol, Audubon Hospitol, One Audubon Plozo Drive, Louisville, KY 40217 (Dr Lansing).

ASCAD, particularly in women older than 50 years of age, as well as in women and men with ASCAD or at high risk for ASCAD. Furthermore, triglyceride blood levels which exceed 1000-2000 mg/dl may predispose patients to acute pancreatitis, eruptive xanthomas, and lipemia retinalis.

Evaluation of the patient with hypertriglyceridemia should begin with correcting secondary causes including drug effects (eg, some diuretics and some beta blockers), systemic disorders (eg, uncontrolled diabetes mellitus or hypothyroidism), and ethanol intake. Dietary therapy includes reduction of dietary fats, reduction in refined sugars (and also simple sugars found in fruit juices for example), and elimination of ethanol if possible. Regular physical exercise may also reduce elevated triglyceride blood levels. If hypertriglyceridemia persists despite correction of the above, drug therapy may be necessary.

Indications for Use

Severe elevations in triglyceride blood levels should be treated to prevent triglyceride-induced acute pancreatitis and eruptive xanthomas. Mild to moderately high triglyceride blood levels should be treated in patients with ASCAD or at high risk for ASCAD as recommended by The National Institutes of Health Consensus Development Conference.[2]

In patients with severe hypertriglyceridemia who are at risk or present with acute pancreatitis, eruptive xanthomas, or lipemia retinalis, the drugs of choice include fibrates, niacin, or fish oils. Fibrates and fish oils are particularly effective in reducing elevated triglyceride blood levels. In patients resistant to single drug therapy (such as gemfibrozil alone), combination therapy of fibrates with fish oil therapy may be efficacious.

In patients with hypertriglyceridemia with ASCAD or at risk for ASCAD, fibrates and niacin are the drugs of choice. Definitive studies comparing the reduction of ASCAD with fibrates vs niacin vs fish oils have not yet been performed. However, the fibrate gemfibrozil has been shown in a large primary prevention trial to reduce the onset of ASCAD in men with combined hyperlipidemia and low HDL cholesterol blood levels.[3] The fibrate clofibrate has been associated with gastrointestinal cancers; therefore the use of this agent is declining.[4] It should be noted that gemfibrozil has not as yet been shown to be effective in secondary prevention trials (ie, in patients with ASCAD) to reduce the progression or induce regression of ASCAD. Also, as with fish oils, many patients with hypertriglyceridemia treated with fibrates may experience a rise in LDL cholesterol blood levels.

Niacin has been shown in secondary prevention trials to reduce the progression of coronary artery disease and reduce overall mortality.[5] Niacin with resin has also been shown to reduce progression and, in some cases, induce regression of coronary artery disease as documented by angiographic studies.[6] In addition to moderate lowering of elevated triglyceride blood levels, niacin is effective in lowering LDL cholesterol and increasing HDL cholesterol blood levels.

Approximately 20 years ago, population studies demonstrated that Eskimos in Greenland and Alaska, who ingest marine fish oils as much as 7 gm/day (compared with an average of 0.06 gm/day in modern Western diets), had a surprisingly low incidence of atherosclerotic heart disease, despite the cultural prevalence of a high-fat diet and obesity.[1] Studies have demonstrated a diminished rate of restenosis after percutaneous transluminal coronary angioplasty,[1] while others have shown a reduced mortality from sudden death resulting from arrhythmia in patients taking fish oil concentrate for treatment of dyslipidemia.[7] However, not all trials have shown such favorable results. In addition to reducing elevated triglyceride blood levels, fish oil therapy may also increase LDL and HDL cholesterol blood levels.

In patients who refuse or wish to avoid "drug therapy" for hypertriglyceridemia, fish oil supplementation is sometimes an acceptable alternative. Many patients feel, and some studies suggest, that ASCAD can be treated with intense dietary therapy and life-style changes alone.[8-10] Many patients who are philosophically resistant to lipid-acting "drug" therapy for ASCAD prevention readily accept "dietary" treatment with supplementation fish oil therapy. In view of the limited

Table 1. Same indications for fish oil treatment af patients with hypertriglyceridemia.

- Prevention of acute pancreatitis, eruptive xanthamas, and lipemia retinals
- Prevention of atherosclerotic cardiovascular disease in:
  1. Patients with, or who are at high risk for atherasclerosis who have elevated triglyceride blaad levels despite diet, exercise, fibrates and/or niacin.
  2. Patients wha wish ta try dietary supplement to lower elevated triglyceride blaod levels before starting "drug" treatment with fibrates ar niacin.
  3. Patients who cannat afford ather triglyceride-lowering drugs.

number of trials demonstrating efficacy of fibrates in prevention of ASCAD, and in view of at least some clinical trials suggesting benefit of omega 3 fatty acid therapy, fish oil therapy may be an acceptable alternative for these patients.

Dosing, Side Effects, and Drug Interactions

Fish oils are generally found in health food suppliers in 1000 mg gel capsule concentrates of approximately 300-600 mg of EPA and DHA. Liquid preparations such as cod liver oil are not generally recommended due to the potential risk of vitamin A and D toxicity. The starting dose is typically 1-2 capsules with each meal (three times a day). This may be increased to 6 capsules three times a day. Due to the frequent increase in LDL cholesterol blood levels with fish oil therapy, "cholesterol-free" preparations are now available. However, because cholesterol-containing fish oil preparations contribute little to overall dietary cholesterol, and because dietary cholesterol often has limited effect on blood cholesterol levels, it is questionable as to whether cholesterol-free preparations provide any major advantages.

The most common adverse side effects are nausea and other gastrointestinal complaints. A fishy after-taste sometimes inhibits compliance. The amount and frequency of treatment (2-6 capsules three times a day) may also further reduce compliance. However, these problems can sometimes be overcome if fish oils are taken with meals and if patients are made aware of the substantial savings in cost compared to other lipid-lowering agents such as fibrates.

Other side effects include prolongation of bleeding time. This occurs because omega-3 fatty acids are precursors to prostaglandins that may decrease platelet aggregation. Theoretically, this increases the risk of hemorrhage. However, it should be noted that significant abnormal bleeding has not been reported in numerous clinical trials of fish oil therapy. In fact, the decrease in platelet aggregation may be advantageous in decreasing the risk of acute thrombotic myocardial infarction.

In patients at risk for abnormal bleeding, bleeding time should be monitored. Patients should be instructed to inform physicians and dentists that fish oils are being taken, particularly before any surgical procedure. If aspirin or nonsteroidal anti-inflammatory agents are also being used, increased bleeding tendency (as documented by prolonged bleeding time) may be increased. Bleeding tendency may also be increased in patients receiving anticoagulant therapy such as coumadin.

Increase in glucose levels in patients with diabetes mellitus or glucose intolerance has also been described.[11] However, this effect is usually minimal and often transient.

Table 2. Side effects and drug interactions with fish oil therapy

Comman side effects
Decreased platelet aggregation with increased bleeding time
Increase in LDL cholesterol blood levels
Nausea, gastritis
Rare side effects
Increased bleeding tendency
Increase in blood sugar
Taxic hypervitaminasis (with cad liver oil)
Diarrhea
Drug interactions
May increase bleeding tendency with aspirin ar ather nansteroidal anti-inflammatary drugs that decrease platelet aggregation
May require increase in insulin ar oral hypoglycemic dose in patients with diabetes mellitus

Conclusion

Fish oil concentrate (omega-3 fatty acids) provides a rapid, effective treatment for hypertriglyceridemia. Reduction in elevated triglyceride blood levels may reduce the progression of disease in patients with ASCAD or at high risk for ASCAD. Reduction in severe elevations in triglyceride blood levels may also reduce the risk of acute pancreatitis, eruptive xanthomas, and lipemia retinalis. Fish oils rich in omega-3 fatty acids are generally well tolerated and may be a useful treatment modality for many patients.

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KMA Annual Meeting
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Louisville, KY

Kentucky Medical Association
Spring Schedule
Practice Management Workshops

Financial Management
March 22, 1994

Patient Flow Management
March 23, 1994

Kentucky Inn - Lexington
Cosponsored with Fayette County Medical Society
9 am - 4 pm; Registration fee: $195 each workshop

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March 24-25, 1994
Jefferson County Medical Society Office
101 W. Chestnut St., Louisville

A 1-1/2 day practice management workshop designed specifically for physicians entering the practice of medicine or leaving group practices. Topics: Practice alternatives, practice setting and practice-marketing techniques, financing your practice, medical records, patient management, personnel and financial management techniques.

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April 20, 1994 - Lexington
April 21, 1994 - Louisville

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Why Practice Medicine in Kentucky?

"I really hope the Governor doesn't institute rate setting. . . . It has never shown to be effective, and it may be a disincentive for people to develop managed care programs."

One Sunday, not long ago, I was reading films in the x-ray department when a physician colleague stopped by and stated, "I'm looking for another state where I can practice medicine."

Shocked, I murmured, "Why?"

"Rate setting," he said. "The Governor wants to institute rate setting. First, the physician tax, now this. Kentucky is a hostile environment for doctors. I want to practice somewhere where there is no physician tax, no rate setting, and where the Medicaid money isn't reallocated for some other purpose."

"Yes, it's hard to find time to practice medicine anymore," I said. "In both my private and academic practices it's the same. Time previously spent on educating myself, peers, or patients is now spent on learning about managed care contracts, writing letters to legislators, and grappling with all of the issues of trying to prepare for the changes of proposed health care reform."

A few hours later our conversation came to an end and I was left to ponder the proposed alternatives to the current health care delivery system. After hours of intensive training in health reform, some facts seem to be almost incontrovertible:

1. Health care costs appear to be declining, at least in part, due to managed care.

2. Statistics show that price setting and price controls appear to decrease the quality of care and only transiently effect the costs as the response to fee setting appears to be an increase in volume and the creative pricing to circumvent the price controls.

3. Managed care appears to be improving quality of care and reducing inefficiency within the system which lowers costs and appears to affect permanent change.

4. Physicians can effectively be partners with managed care plans, not employees of the plan.

5. Physicians should align with one or more physician provider organizations to be in the most advantageous position for access to patients and to maintain the greatest flexibility and control.

6. Hospitals and physicians not prepared for managed care will have a difficult time surviving professionally.

I really hope the Governor doesn't institute rate setting, I thought. It has never shown to be effective, and it may be a disincentive for people to develop managed care programs. And besides, I'd sure hate to lose ol' John!

Jannice O. Aaron, MD

THE JAMES...THE NEX



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Cancer crosses all cultures and all nationalities without exception. So it stands to reason that the treatment and eventual cure of a condition experienced worldwide would require talent and intellect from around the globe.

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roach to research is so inte-
ed, the lag time between labo-
ry breakthroughs and practi-
application is dramatically
eased. Collaboration between research teams and clinical specialists of the Comprehensive Cancer Center, which are composed of University graduate programs in chemistry, biological sciences, pharmacy and veterinary medicine, has enabled research efforts to advance efficiently while benefiting from the resources of one of the nation's leading University medical programs.

Beginning with the very first blueprints, The James was designed to provide researchers with the facilities, technology and opportunity to conduct their best work. Today, it is a reality that is dedicated to offering hope to the current generation of cancer patients as well as the promise of eradication to those in the future.

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The purpose of the Forum is to open discussion of politically salient issues in health care. The Forum is devoted to open and honest discussion about how to create laws, health plans, and administrative structures that balance insurance resources against the desires of citizens to consume them and health care providers to dispense them. Several themes to be explored include high technology insurance payments; rights of individuals to a basic health benefit package; and creation, ownership, and freedom to buy health care with private funds.

Speakers include John Kitzhaber, MD, former President, Oregon Senate; E. Haavi Morreim, PhD, Professor, Human Values and Ethics, University of Tennessee; Michael Rie, MD, Associate Professor of Anesthesiology and Surgery, University of Kentucky College of Medicine; and H. Tristan Englehardt, Jr., MD, PhD, Professor of Medicine and Community Medicine, Baylor College of Medicine, Houston, Texas.

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Doctors' Day Project Against Violence



Gloria J. Griffin

The KMA Alliance needs your support in our statewide Doctors' Day project against violence.

KMAA members in these 14 Kentucky counties, along with 28 members-at-large, chose to participate with the state and national organization for physician spouses:

Boyd
Daviess
Fayette
Henderson
Hopkins
Jefferson
Laurel
McCracken
Northern Kentucky
Perry
Pulaski
Rowan
Warren
Whitley

Collectively, these 1,100 physician spouses are uniting in our commitment to the family of medicine, actively working in their communities on health related projects that will benefit the citizens of Kentucky.

In 1991, President George Bush signed a proclamation designating March 30 as national Doctors' Day. Traditionally, the March *KMA Journal* Alliance page would review the history of Doctors' Day and give you an overview of how counties across the state are celebrating Doctors' Day.

This year, in honor of Doctors' Day, the KMA Alliance is encouraging physician spouses and their families to participate in a statewide project to publicly denounce violence. We are appalled that more children under the age of 18 will be killed by acts of violence this year than when the polio epidemic was at its highest level. It will require the commitment of all physician spouses in the state to help stop the violence that is destroying families and communities across the state.

I hope that you choose to help us make an impact on the future of the lives of people in your community and actively participate in our statewide Doctors' Day project. The county presidents and Doctors' Day chairmen in the organized counties have already received information on this project. I know this is like "mission impossible," but if you decide to take this challenge and participate in the project, please contact me.

A culmination of all projects physicians' spouses have been involved in this year will be presented at the KMA Alliance Annual Meeting in April. All physician spouses are encouraged to attend, so make your plans now for the April 18 and 19, 1994, meeting at the Seelbach Hotel in Louisville. There will be additional information in the convention issue of the KMA Alliance *Bluegrass News* and the April issue of the *KMA Journal.*

Gloria J. Griffin

KMA Alliance President

"Mark Your Calendar! March 30 is National Doctors' Day"

The time it takes to get to the park could keep you from hitting your child.



Next time you feel like hitting your child, try another approach. Do something like playing this game together. Or any game that gives you both the time you need to cool off. Try it out. You'll both be glad you did. For a free booklet, Write "Parenting," P.O. Box 2866P, Chicago, Illinois 60690.

Take time out. Don't take it out on your child.

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National Committee for Prevention of Child Abuse

1994

APRIL

16-22 — 79th Annual American Occupational Health Conference, Hyatt Regency Chicago. Sponsored by the American College of Occupational and Environmental Medicine. Contact: ACOEM, 55 W Seegers Rd, Arlington Heights, IL 60005; 708/228-6850; FAX 708/228-1856.

MAY

2-4 — First Annual Postgraduate Clinical Forensic Medicine Conference, Brown Hotel, Louisville, KY. Contact: Write Clinical Forensic Medicine Conference, Dept of Emergency Medicine, University of Louisville, Louisville, KY 40292, or call 502/852-5689 or FAX 502/852-0066.

JUNE

9-11 — 39th Great Smoky Mountains Pediatric Seminar, Park Vista Hotel, Gatlinburg, TN. Contact: Continuing Medical Education, 1924 Alcoa Highway, D-116, Knoxville, TN 37920; 615/544-9190.

23-25 — First Annual Meeting of the Southern Association for Family Practice, The Woodlands, Williamsburg, VA. Contact: Department of Education, 205/945-1840.

JULY

28-30 — Seventh Annual Meeting of the Southern Association for Oncology, Jekyll Island Club Hotel, Jekyll Island, GA. Contact: Write to Linda Willingham, Coordinator, SAO, PO Box 190088, Birmingham, AL 35219-0088 or call 205/942-0530.

AUGUST

19-21 — Southern Orthopaedic Association 1994 Annual Meeting, The Southampton Princess, Bermuda. Contact: Linda Willingham, 205/945-1848.

SEPTEMBER

24 — Eleventh Annual Ophthalmology Seminar: Uveitis Update. Audubon Regional Medical Center, Louisville, KY. Contact: Cathy Edens, 240 Audubon Medical Plaza, Louisville, KY 40217; 502/636-2823.

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Two New Officers Elected to KMA Board of Trustees

During the 1993 KMA annual House of Delegates meeting held in Louisville, two new officers were elected to serve on the Board of Trustees. KMA congratulates the following members on their election and thanks them for their valuable leadership.

G. Irene Minor, MD, a Berea family practitioner, was elected to serve a 3-year term as 11th District Trustee.

Dr Minor has been an involved member of KMA since 1990, having served as a Delegate for Madison County since her first year of membership. She also currently serves on the Nominating Committee and the Public Education Committee. Dr Minor is a past president of the Madison County Medical Society and is extensively involved in other professional and civic organizations including membership on the Berea Hospital Board and the Kenpac Board of Directors, Alumni-Leadership Madison County, and the Attorney General's Task Force on Family Violence.

Dr Minor, 44, graduated magna cum laude from Miami University, Oxford, Ohio, in 1977. She earned her MD from the University of Kentucky College of Medicine in 1981, followed by an internship at St. Mary's Medical Center in Evansville, Indiana.



A staff member of Berea Hospital and Berea Hospital Emergency Room, Dr Minor is also affiliated with Spectrum Emergency Services.

Timothy K. Hulsey, MD, was elected to serve a 3-year term as 6th District Trustee.

A plastic surgeon, Dr Hulsey practices in Bowling Green. He earned his undergraduate degree from Western Kentucky University in 1970 and an MD from Vanderbilt University School of Medicine, Nashville, Tennessee, in 1974. Postgraduate education included serving a general surgery residency at Vanderbilt Hospital in 1980-82.

Dr Hulsey, 44, is a member of the American Board of Plastic Surgery, Tri-County Medical Society, Kentucky Society of Plastic and Reconstructive Surgeons, American Society of Plastic and Reconstructive Surgeons, and the Southeastern Society of Plastic and Reconstructive Surgeons.

A member of KMA since 1983, Dr Hulsey was elected in 1993 as an Alternate Delegate for Warren County.

(Photo not available)

PEOPLE

Gary L. Partin, MD, Adair County, was named recipient of the 1993 Best Notifiable Disease Reporter Award. Physicians across the state were nominated by local health departments and the winner was selected from 10 finalists, each of whom received a certificate of appreciation. Disease reporting, cooperation with local health department prevention activities, and public health awareness were selection criteria. **Reginald Finger, MD, MPH,** Division of Epidemiology, made the presentation.

The University of Louisville Alumni Association presented **Linda Gleis, MD,** with their *Order of Merit Award* during a luncheon in her honor at the University Club and Alumni Center Ballroom. Dr Gleis was honored for distinctive achievements in her profession and for her community service.

William S. Smock, MD, Louisville, won second place and a cash award for his scientific paper presentation entitled, "Practical Applications of Clinical Forensic Medicine in the Emergency Department," given during the 87th Annual Scientific Assembly of the Southern Medical Association held in New Orleans, Louisiana. Dr Smock presented his research paper during the meetings of SMA's Section on Emergency Medicine. Dr Smock is affiliated with The Clinical Forensic Medicine of the Department of Emergency Medicine at the University of Louisville.

Three residents from the U of L Department of Psychiatry and Behavioral Sciences recently received national honors.

Walter Butler, MD, JD, was chosen as a *Rappeport Fellow* of the American Academy of Psychiatry and the Law, and **Karen W. Head, MD,** and **Jon M. Miller, MD, PhD,** were among the 15 named APA/*Burroughs Wellcome Fellows.* The National Institute of Mental Health also recognized Dr Miller as one of 14 "Outstanding Residents."

Susan Galandiuk, MD, was recently honored as a winner in the U of L Young Investigator Awards.

The annual honor is awarded to assistant professors who have attained substantial research records. Dr Galandiuk's investigations have led to her authorship or co-authorship of 17 publications in peer-reviewed journals in the past 3 years. She also has had papers presented twice during the past 4 years on the program of the American Surgical Association.

Dr Galandiuk's research involves work with microbiology on issues of trauma, shock, and sepsis and with biochemistry on genetic components of colon cancer.

Kenneth R. Crabtree, MD, Gamaliel (Monroe County), is currently serving as secretary of the Southern Association for Family Practice, an affiliate of the Southern Medical Association. This group will hold its first annual meeting June 23-25 at The Woodlands, Williamsburg, VA.

T. Rothrock Miller, MD, is having a one-man art exhibit consisting of 40 to 50 of his watercolor paintings to be shown in the gallery of the Central Bank in Lexington. The show will run during the month of March.

Jerry L. Jamison, MD, Jamestown, has been elected a Fellow of the American College of Physicians, the professional organization of internists. Dr Jamison works with Southern Indiana Medical Associates in Clarksville, IN, and is affiliated with Clark Memorial Hospital.

UPDATES

Jackson Purchase Cardiovascular Society

A group of physicians and nurses in the Paducah area have formed the Jackson Purchase Cardiovascular Society. The society's goals are to provide regularly scheduled and accredited CME activities devoted to cardiovascular disease and treatment and to provide scheduled opportunities for health care professionals from many disciplines the chance to discuss common problems and solutions in a collegial setting.

The JPCVS was formed on January 19, 1993. **Lowell F. Roberts, MD,** and **Barry F. Riggs, MD,** were elected president and vice-president, respectively, and **Charles B. Ross, MD,** was elected secretary-treasurer. Karen S. Talbott, BSN, was elected AACN Liaison. Successful meetings were held in March, May, September, and November and included topics ranging from renovascular hypertension caused by fibromuscular dysplasia of the renal arteries to directional atherectomy in the treatment of coronary artery occlusive disease. Over the course of the first year, society membership grew to 32 physicians representing 10 medical/surgical specialties and 70 nurses and various technologists who directly participate in the care of cardiovascular patients.

Physicians and cardiovascular nurses/technologists in the Western Kentucky region interested in participating in the JPCVS may contact Charles B. Ross, MD, 502/441-4322.

HCFA Approval of COLA Official

On December 29, 1993, the Health Care Financing Administration

(HCFA) announced that the Commission on Office Laboratory Accreditation (COLA) is officially approved. COLA is the first major accrediting organization to obtain deeming authority under CLIA '88 and the only accrediting organization for the office laboratory.

This approval means that office laboratories accredited by COLA are "deemed" to meet the federal standards. Accreditation by COLA fulfills all CLIA requirements including the biennial CLIA. Once an individual applies to COLA, the laboratory comes under the COLA umbrella, not the federal CLIA program. The primary relationship will be with the COLA program, not HCFA.

In addition to fulfilling all CLIA requirements through COLA accreditation, COLA prepares the office laboratory by providing the physician the opportunity to conduct a comprehensive self-assessment. Contact COLA at 301/588-5882 for more information.

Kentucky Cancer Registry Reveals Latest Cancer Trends

The Kentucky Cancer Registry presented its newly compiled *1992 Cancer Incidence Report* to the legislative Health and Welfare Committee on January 11, 1994, in Frankfort. This report is the state's only source of population based incidence data on cancer. It represents the most current information available on the occurrence and distribution of common types of cancers in Kentucky.

The report indicates:

- The incidence of lung cancer among men is much higher in Kentucky than in other parts of the United States.
- Breast cancer incidence rates in the urban areas of Lexington, Louisville, and Paducah are higher than in other areas of the state.
- Women in parts of Eastern Kentucky could benefit from intensified breast cancer screening efforts; fewer of the breast cancer cases diagnosed there than elsewhere are at an early stage, when breast cancer is most treatable.
- Cervix cancer incidence rates remain higher in the eastern part of Kentucky; colorectal cancer incidence rates are higher in the counties that border the Ohio River, from Louisville to Maysville. Both of these areas have shown higher mortality rates from cervix and colorectal cancers respectively.

In 1991, 16,872 new cancer cases were diagnosed; in 1992, there were 17,072 new cases. The Registry hopes that the information, reported by county and area development district, will be useful to legislators as they address the complex issues of health care reform.

The Kentucky Cancer Registry, a division of the Kentucky Cancer Program, produced its first report in 1991. Reporting of all cancer cases to the registry was mandated in 1990 by the Kentucky General Assembly.

Don't *Duck* Your Responsibility

The Kentucky Educational Medical Political Action Committee — KEMPAC — needs your support and participation in this time of health care reform. KEMPAC membership and support for 1994 have risen greatly from 1993, but KEMPAC needs support from *all* physicians in Kentucky. Don't *duck* out on joining KEMPAC and helping your peers, your profession, and yourself. If you have not yet joined KEMPAC for 1994, now is your chance. Send a personal check for $100 for yourself and $100 for your spouse to KEMPAC, 301 N Hurstbourne Pkwy, Suite 200, Louisville, KY 40222, today. If you have joined, pass on the word to someone who has not.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Boyd

John K. Borders, Jr, MD — P
PO Box 1447, Ashland 41101
1975, Indiana U

Paul W. Craig, II, MD — IM
2211 Montgomery Ave, Ashland 41101
1983, Medical Col of Georgia

Philip W. Fioret, MD — FP
136 Sunset Ct, Ashland 41101
1981, U of Saskatchewan

Katalin Z. Kovacs, MD — PTH
2201 Lexington Ave, Ashland 41101
1981, Semmelweis U

Bell

Puneet Goenka, MD — IM
PO Box 308, Pineville 40977
1988, Government Med Col, India

Madhan Mohan, MD — IM
PO Box 308, Pineville 40977
1985, Madras U, India

Boyle

Melissa Newhall, MD — FP
416A Walnut, Danville 40422
1989, U of Kentucky

Caldwell

Algimantas L. Jecius, MD — S
PO Box 385, Princeton 42445
1988, Loyola

Carter

Dante R. Oreta, MD — FP
710 Carol Malone Blvd, Grayson 41143
1972, U of Philippines

Daviess

Dayne K. Roberts, MD — R
PO Box 570, Owensboro 42302
1988, Medical Col of Ohio

Graves

George V. Jirak, MD — OBG

408 Heritage Dr, Mayfield 42066
1981, U of Wisconsin

Hardin

Carmen V. Pinto, MD — P
PO Box 2321, Elizabethtown 42702
1985, Michigan State

Harlan

Noormahal Kabani, MD — IM
94 Ballpark Rd, Harlan 40831
1977, Fatima Jinnah Col, Pakistan

Jefferson

Robert W. Bendon, MD — PTH
7019 Breakwater Pl, Prospect 40059
1975, Hahnemann Med Col
Frank O. Bonnarens, MD — ORS
601 S Floyd #200, Louisville 40202
1983, SUNY Brooklyn
Holly W. Brown, MD — OBG
2905 Lilac Way, Louisville 40206
1989, U of Louisville
Karen M. Cost, PhD
8201 Salford Way, Louisville 40222
William A. Hymes, MD — TS
6400 Dutchmans Pky #235, Louisville 40205
1986, SUNY Syracuse
Arthur L. Malkani, MD — ORS
4001 Kresge Way #132, Louisville 40206
1986, Columbia U
Craig S. Roberts, MD — ORS
234 E Gray #564, Louisville 40202
1986, NYU Med Col
Chelsea J. Seale, MD — IM
1963 Deer Park Ave, Louisville 40204
1990, U of Louisville
Michael K. Sowell, MD — PD
250 E Liberty #202, Louisville 40202
1987, U of Arkansas
Suzanne S. Thompson, MD — AN
4001 Dutchmans Ln #LL-F, Louisville 40207
1987, U of Louisville

Laurel

David M. Norris, MD — R
PO Box 1774, London 40743
1989, U of Tennessee

Madison

Elizabeth A. Pedigo, MD — IM
310 Geri St, Richmond 40475
1984, U of Louisville

McCracken

John N. Gillespie, MD — OPH
2315 Broadway, Paducah 42001
1980, U of Louisville

Northern Kentucky

Michelle Andrews, MD — ORS
One Lytle Pl #415, Cincinnati, OH 45202
1985, Hahnemann Med Col
James A. Giffin, MD — S
20 Medical Village Dr #132, Edgewood 41017
1988, USC
Christopher A. Heeb, MD — IM
3040 Village Dr, Edgewood 41017
1990, U of Kentucky
Steven E. Park, MD — TS
802 Ashfield Ct, Covington 41017
1985, U of Chicago
Joseph E. Temming, MD — IM
2600 Alexandria Pk, Highland Heights 41076
1987, Ohio State

Pike

Anbu K. Nadar, MD — ORS
261 Town Mountain Rd, Pikeville 41502
1976, Madras U, India

Rockcastle

James A. Cunningham, MD — FP
Mount Vernon Clinic, Mount Vernon 40456
1979, U of West Indies

Warren

Lisa B. Eberlin, MD — S
PO Box 1590, Bowling Green 42102
1986, Case Western Reserve U
Daniel P. Geis, MD — PTH
632 Newberry St, Bowling Green 42103
1987, Wright State

Whitley

David J. Lauber, MD — S
121 Bishop St #7, Corbin 40701
1988, Oral Roberts U

In-Training

Jefferson

Kirk A. Churukian, MD — PS
Irwin R. Cohen, MD — R
Youssef Dairi, MD — IM
Radhika Donepudi, MD — FP
Tracey S. Fisher, MD — EM
Haeshik S. Gorr, MD — IM
Sohail Ikram, MD — IM
George W. Isaacs, MD — AN
Lindsey A. Nooe, MD — EM
Theresa Pagliuca, MD — IM
Brian L. Schulman, MD — IM
Donna J. Smith, MD — P

DEATHS

Thomas E. Egan, MD
Covington
1932-1993

Thomas E. Egan, MD, a Northern Kentucky pediatrician, died November 10, 1993. Dr Egan was a 1958 graduate of the University of Cincinnati College of Medicine and was a member of KMA.

Roy H. Moore, Jr, MD
Louisville
1915-1994

Roy H. Moore, Jr, MD, a retired general surgeon, died January 6, 1994. Dr Moore served as president of the Jefferson County Medical Society in 1965 and 1966 and was a former vice president of KMA. He earned a Bronze Star for his work in developing sterile containers for transporting medical supplies to combat troops during World War II. Dr Moore graduated from the University of Louisville School of Medicine in 1939 and was a life member of KMA.

George P. Whiteside, MD
Glasgow
1905-1994

George P. Whiteside, MD, a retired general practitioner, died January 22, 1994. Dr Whiteside was a 1941 graduate of the University of Tennessee College of Medicine and was a life member of KMA.

Max L. Garon, MD
Clearwater, FL
1905-1994

Max L. Garon, MD, a retired internal medicine physician, died January 26, 1994. A 1929 graduate of the University of Louisville School of Medicine, Dr Garon was a life member of KMA.

Mark your calendar today!



THE ART OF
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CAGE
Questionnaire

For the Diagnosis of Alcoholism

C = Have you ever felt you should **cut down** on your drinking?

A = Have people **annoyed** you by criticizing your drinking?

G = Have you ever felt bad or **guilty** about your drinking?

E = Have you ever had a drink first thing in the morning (**eyeopener**)?

Positive CAGE Answers:

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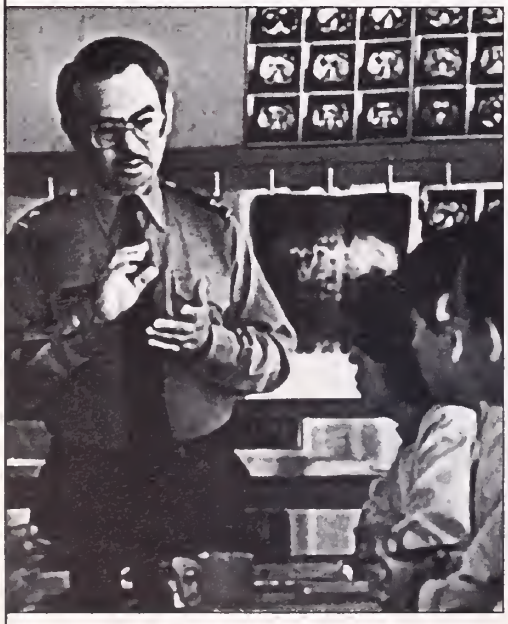
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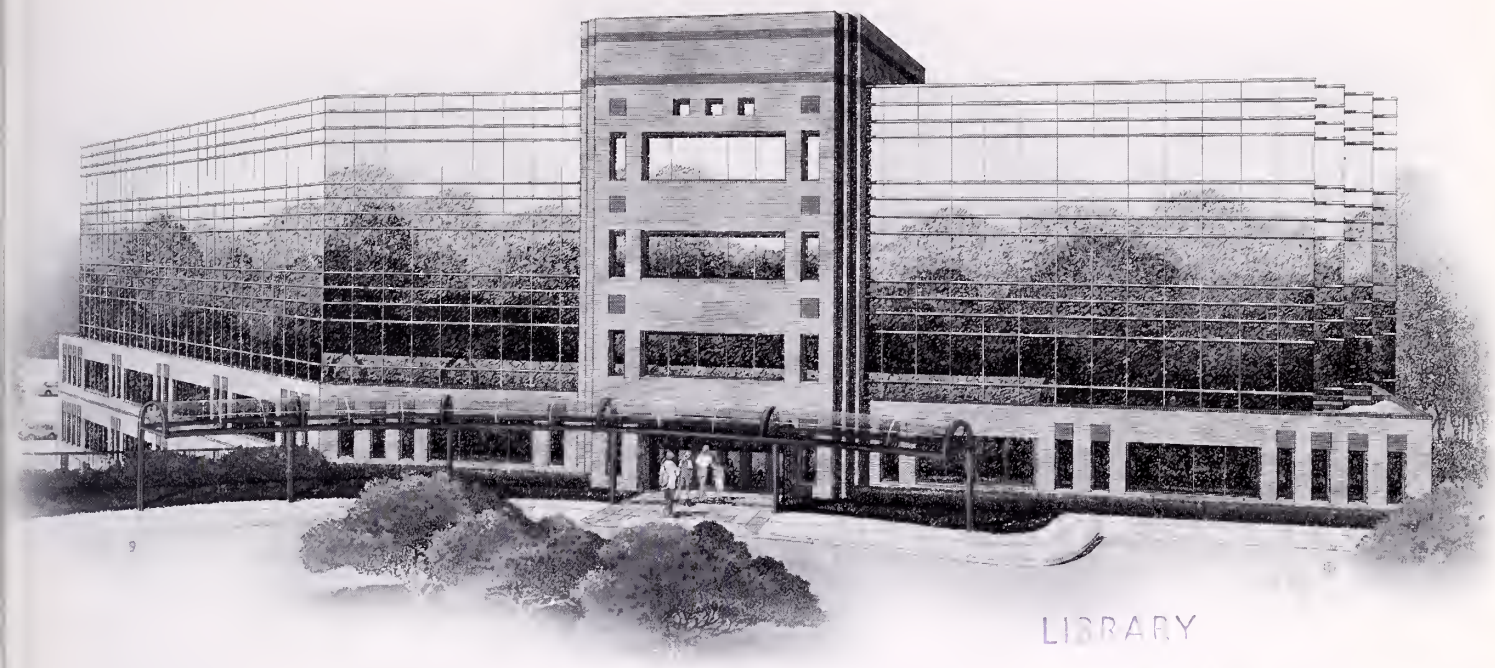
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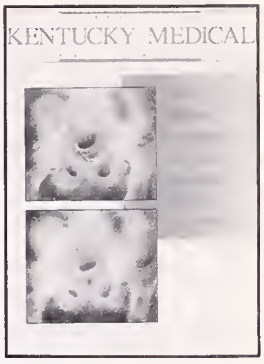
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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Second-class postage paid at Louisville, KY and additional offices. Yearly subscription rates: $25 domestic; $30 foreign. Single issues $3 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association*, 301 N Hurstbourne Pkwy, Suite 200, Louisville, KY 40222-8512. EDITORIAL AND ADVERTISING: Telephone 502/426-6200.

Listed in Index Medicus. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

National advertising representative: State Medical Journal Advertising Bureau, Inc, 11437 W 106th St, Overland Park, KS 66214, phone 800/788-2360.

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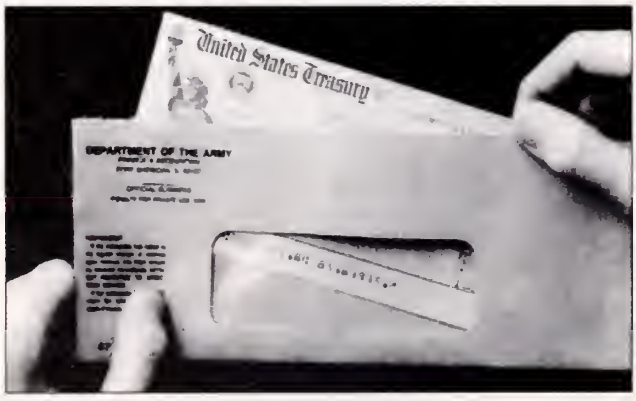
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"'Politics as usual' is inappropriate when Medicaid funding and reimbursement are threatened, when access to quality health care is at risk, and when our elected representatives to Frankfort fail to see or are unwilling to recognize the impact of their political decisions on health care."

As I put pen to paper, the deliberations in the Kentucky General Assembly are rapidly progressing with the current Health Reform Bill under consideration in the Senate.

To the minimally educated in the world of politics, this entire process is confrontational, potentially frustrating, and anxiety producing. On more than one occasion when we have stated that something is illogical or incorrect, we are simply told, "But doctor, you don't understand. This is politics!"

"Politics as usual" does not suffice when we are dealing with health care for the people of this state. "Politics as usual" is inappropriate when Medicaid funding and reimbursement are threatened, when access to quality health care is at risk, and when our elected representatives to Frankfort fail to see or are unwilling to recognize the impact of their political decisions on health care. The unwillingness of government to address the issue of appropriately funding Medicaid in this state remains of greatest concern and we will be addressing this issue repeatedly.

As physicians protecting patient care and serving as advocates for our patients and the profession, we bear a responsibility to be vocal, aggressive, and willing to commit time and resources to the political process which will eventually determine the fate of health care, both locally and at the national level. The health system reform activity will not cease at the close of the Kentucky General Assembly. This will be an ongoing process in Frankfort. The activity in Washington is escalating — a concerted bipartisan effort to effect a meaningful outcome.

I implore you, not only as physicians dedicated to your profession but as citizens of the Commonwealth, to take a critical look at the elected senators and representatives from your districts. Are these people really knowledgeable about the issues and dedicated to the *improvement* of life in this state? Are they willing to listen and learn without being hostile, defensive, and punitive? As leaders in our respective communities, we have an excellent opportunity to interact with all people to bring about change; however, it will not be easily accomplished or without some sacrifice.

I applaud those in the medical community who have become involved in the political process, but a greater commitment from all of us is needed.

In protecting patient care and the rights of our patients — motives matter, dignity and honesty count, high ethical standards and accountability should prevail, and the rewards for our patients and the profession can be considerable.

Ardis D. Hoven, MD
KMA President

Paradoxical Poor Prognosis of Myeloma Patients Who Demonstrate Complete Healing of Bone Lesions Following Treatment

Dennis W. Wulfeck, MD, MS; Terry E. Williams, MD, PhD



Multiple myeloma is the most common primary malignant bone neoplasm in adults, primarily over the age of 40. The most common radiographic findings include osteopenia, lytic lesions, and pathologic fractures. Although marked bone repair and healing can occur following therapy, this is often, paradoxically, a poor prognostic indicator.

We describe a case of an extreme example of skeletal repair in a patient with multiple myeloma following radiation and chemotherapy.

A 62-year-old white male who had no significant past medical history was admitted with a 1-year history of severe left hip pain. A radiograph of the pelvis demonstrated complete destruction of the superior pubic ramus on the left side, part of the inferior pubic ramus, and much of the acetabulum with a protrusio acetabuli of the femoral head and a soft-tissue mass in the left hemipelvis (Fig 1).

Laboratory evaluation revealed an increased serum calcium, increased total protein, and a normocytic normochromic anemia. The peripheral blood smear revealed rouleaux formation. Subsequent serum protein electrophoresis was consistent with monoclonal gammopathy, lgA kappa. Bone marrow biopsy demonstrated infiltration by atypical plasma cells.

A radiographic bone survey demonstrated diffuse, "punched out," lytic lesions throughout the skeleton, including the calvarium (Fig 2). The differential diagnosis of multiple lytic lesions includes: (1) metastases, (2) multiple myeloma, (3) fibrous dysplasia, (4) enchondromas, (5) eosinophilic granuloma, (6) infection, and (7) hyperparathyroidism. The patient was diagnosed with multiple myeloma.

The patient received radiation therapy and physical therapy resulting in marked symptomatic improvement. Three courses of prednisone and melphalan chemotherapy were administered. A follow-up film obtained 5 months later demonstrated marked evidence of healing with bone repair of the pubic rami and ischium (Fig 3). Despite the encouraging radiographic appearance, the patient died 3 months later.

Discussion

Multiple myeloma is a disseminated malignant disease of the bone marrow. It is the most common primary malignant bone neoplasm in adults and is predominantly a disease of patients over the age of 40. The presentation is highly variable involving many organ systems. Bone pain is the most common presentation. In a large percentage of cases, pathologic fractures may be the inciting event that brings the patient to medical attention.

Laboratory examination may reveal an elevated serum calcium, normocytic normochromic anemia, elevated total plasma protein, and normal urine hydroxyproline and serum alkaline phosphatase. The most abundant paraproteins of multiple myeloma are lgG and lgA.

Skeletal changes are apparent radiographically in the majority of cases. The most common sites of involvement are in the axial skeleton (skull, spine, pelvis, ribs, clavicle, and mandible). The proximal appendicular skeleton or areas involved in production of red marrow are also involved. The most common skeletal changes associated with multiple myeloma include osteopenia, lytic lesions, and pathologic fractures. Nuclear medicine bone-seeking isotopes demonstrate augmented uptake in 20% to 45% of cases.

From the Department of Diognostic Radiology, Humono Hospital University of Louisville, Louisville, KY 40202.

Reprint requests to Diagnostic Radiology, Humana Hospitol University of Louisville, 530 S Jockson St, Louisville, KY 40202 (Dr Wulfeck).



Fig 1 — An AP film of the pelvis demonstrates marked skeletal destruction of the left ischium and pubis with associated soft tissue mass.



Fig 2 — Lateral film of the skull demonstrates multiple "punched out" lytic lesions.



Fig 3 — Repeat pelvis, 5 months post-therapy demonstrates marked skeletal repair.

A relatively rare variant of multiple myeloma is the sclerotic form. It accounts for between 1% to 3% of multiple myeloma cases. This form is associated with POEMS syndrome (Polyneuropathy, Organomegaly, Endocrine abnormalities, M-protein, and Skin changes).[1]

Treatment for the most part involves a variety of combination chemotherapy. There have been a number of reports indicating that X-ray changes may be a reliable predictor of outcome.[2] However, more recently, studies have indicated that prognosis, radiographic presentation and, paradoxically, radiographic evidence of healing may correlate poorly as documented by Smith, et al.[3] In this study, the shortest survival was seen in patients with normal X-rays at presentation while the longest survival was noted in those with minimal lytic changes. Patients with osteoporosis alone or extensive lytic lesions at presentation had intermediate survivals.

Furthermore, on follow-up after chemotherapy, the longest survival was documented in those patients with stable (unchanged) X-rays. Radiographic evidence of healing as well as progressive disease following therapy both correlated with poor survival rates.

It has been reported that extent of radiologic changes shows the closest correlation with measured tumor cell mass and survival.[4] Therefore, poor survival in patients with improved radiological appearance following therapy may reflect a low response rate and short duration of remission.

The additional major prognostic factors include serum calcium, hemoglobin, M-band, renal function, and performance status. In the study by Smith, et al, the only significant differences among the major prognostic factors were in the low incidence of hypercalcemia and high incidence of anemia among patients with normal X-rays at presentation. This subset of patients also had a low M-band and comparatively good performance status. Also, it has been suggested that the extent of bone healing following treatment may represent an uncoupling of bone formation and resorption with low levels of osteoclast activating factor.[5]

Together, these findings indicate that the current clinical staging system for multiple myeloma, which includes X-ray findings, may prove unreliable in certain patients. In addition to the surprisingly poor prognosis of patients with normal X-rays at presentation, it appears that radiographic improvement following chemotherapy is also an adverse prognostic sign. This theme sug-

gests that chemotherapy should be intensified in those patients with evidence of bone healing. The marked radiographic evidence of healing in this patient following chemotherapy did, paradoxically, portend a poor outcome.

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Gastrointestinal Hemorrhage and Small Cell Carcinoma

Troy Payne, MD; Stephanie Mayfield-Stokes, MD; John Powers, MD; Thomas M. Roy, MD

From the Department of Internol Medicine ond the Deportment of Pothology, University of Louisville School of Medicine, ond Louisville Veterons Administrotion Medicol Center, Louisville, KY 40292.

Despite widespread dissemination of primary lung carcinoma by lymphangitic and hematogenous routes, acute gastrointestinal signs and symptoms are rarely presenting symptoms for bronchogenic carcinoma. We present a patient with small cell carcinoma of the lung who came to medical attention because of a lower gastrointestinal hemorrhage. In the absence of radiographically apparent pulmonary disease, the correct diagnosis was suggested by the biopsy specimens of the colon.

Small cell carcinoma of the lung was established as a distinct type of pulmonary tumor by Azzopardi in 1959.[1] Presently, small cell carcinomas account for approximately one quarter of all cancers arising in the lung.[2] The tumor is biologically aggressive and involves males at an earlier age than other varieties of lung cancer. Metastases from the primary lung tumor is widespread and unpredictable, resulting in a dismal prognosis.

The neoplasm is derived from argentaffin cells. These cells, when examined by electron microscopy, are found to contain membrane-bound dense core granules of the neurosecretory type characteristic of amine precursor and decarboxylation (APUD) activity.

Since similar cells are located in other organs of the body, it should not be surprising that primary extrapulmonary small cell carcinomas have been recognized. Small cell carcinoma has been reported in the larynx, thymus, esophagus, pancreas, uterine, cervix, prostate, stomach, colon, and rectum.[3]

Our patient presents an interesting diagnostic puzzle. Was the presence of small cell carcinoma in the cecum of the large bowel a primary neoplasm or a metastatic focus from a primary bronchogenic small cell carcinoma? While there is no clear answer, we would like to review how each possibility is noteworthy.

Case Report

A 66-year-old white male with a history of intermittent atrial fibrillation and atherosclerotic coronary artery disease was admitted to the Louisville Veterans Administration Medical Center with midepigastric discomfort and a 2-day history of melena. He denied hematemesis, hemoptysis, nausea, or vomiting. The patient had lost 13 pounds during the previous 4 months. His serum hemoglobin had dropped by four grams since measured 4 months earlier.

He had undergone a four vessel coronary artery bypass graft after suffering a myocardial infarction 8 years before this admission. He had intermittent atrial fibrillation and was treated with daily Digoxin, Lasix, and Coumadin. He had an 80 pack-year history of cigarette smoking. He denied the use of alcohol and over-the-counter medications. He had no significant occupational or recreational exposures to hazardous materials.

The physical examination confirmed mild midepigastric tenderness to deep palpation without rebound tenderness. No masses were palpable. The liver was enlarged at 16 cm as estimated by the range of dullness to percussion in the right midclavicular line. Melena was evident on rectal examination. The breath sounds were decreased over the left base, but auscultation and percussion were otherwise normal.

Nasogastric aspirate was negative for blood. His hemoglobin was 8.5 gm/dl and the hematocrit was 24.2. His platelets were measured as 125,000/cc3, the reticulocyte count was 12.7, and total white blood cell count was 13,600/cc3. The prothrombin time (PT) was 23.6 seconds and the partial thromboplastin time (PTT) 35 seconds. His serum LDH was elevated to 720 IU. His SGPT was increased to 63 IU. Other chemistries were within normal limits.

The admission chest radiograph was compared with a film taken 4 months earlier. It was interpreted as showing old bilateral rib fractures,

chronic left parenchymal fibrosis, and suggestion of mild elevation of the left hemidiaphragm.

The patient's Coumadin was discontinued. Imaging of the upper gastrointestinal tract and small bowel were unremarkable. An esophagogastroduodenoscopy (EGD) was unremarkable. Two polyps were found and removed at colonoscopy. A 0.6 cm nodular polyp was found at the hepatic flexure. A larger sessile polyp approximately 1.2 cm in length was found at the cecum. The nodular polyp was an adenomatous polyp, but the cecal sessile polyp was an undifferentiated small cell carcinoma.

Because primary or metastatic small cell carcinoma of the colon is unusual, computed tomography of the lung and mediastinum was obtained. This imaging modality showed evidence of prior sternotomy, and a small left lower lobe infiltrate and a small pleural effusion. There were no mediastinal masses or lymphadenopathy.

Thoracentesis was performed with ultrasound guidance, but the pleural fluid was nondiagnostic. Direct visualization of the left lower bronchi suggested extrinsic compression, but no endobronchial lesions were seen. Transbronchial biopsies obtained from the left lower lobe contained cells consistent with undifferentiated small cell carcinoma.

Additional imaging studies of the head and the bones were normal. Computed tomography of the abdomen showed multiple areas of low attenuation consistent with metastatic carcinoma to the liver. The patient began a modified chemotherapeutic regimen with CCNU, Methotrexate, and Cyclophosphamide. He continues to be followed in the oncology clinic.

Discussion

Carcinoid tumors and small cell carcinomas are similar in that both contain intracellular neurosecretory granules that can be identified by immunohistochemistry techniques. It is now accepted that both tumors share the same endodermal cell origin.[4] The gastrointestinal tract is a common site in which carcinoid tumors develop. On the other hand, primary small cell carcinomas of the colon are unusual. They account for only 0.2% of all malignant neoplasms of the large bowel.[5] Fewer than 100 such patients have been reported in the medical literature.[6]

When a primary small cell carcinoma occurs in the colon, the rectum (41%) and the cecum (22%) are the areas most often involved. Small cell carcinomas of the large intestine typically metastasize to the liver early in the course of tumor growth. The patient commonly presents with signs and symptoms related to the primary site of involvement.

Based on these observations, it is conceivable that our patient with midepigastric pain and melena had developed a primary small cell carcinoma in the cecum. We are hesitant to presume this, however, since the lesion was identified and removed as a sessile polyp. Primary small cell carcinomas of the bowel have uniformly been described as ulcerating lesions with everted edges. We could not find a report in the medical literature describing primary small cell of the cecum presenting as a polyp.[7]

Although we cannot dismiss the possibility that the cecal polyp was an independent primary small cell tumor occurring synchronously with the lung tumor, we feel this is unlikely based on the available information regarding multiple primary cancers.[8] Most authorities emphasize that the overwhelming majority of extrapulmonary small cell carcinomas are of primary pulmonary origin. Every effort to exclude the lung as a site of a primary tumor is expected before an extrapulmonary lesion is declared a primary tumor.

The lung was involved in our patient, so that the most probable scenario is that of bronchogenic neoplasm metastasizing to the cecal area. This clinical evolution is less exciting than a primary small cell carcinoma with a sessile polypoid appearance, but is also rare.

Gastrointestinal metastases from all types of bronchogenic carcinoma is estimated to occur in approximately 14% of patients.[9] The esophagus is the most common site of metastatic involvement. Metastatic involvement of the colon is an unusual feature of primary bronchogenic carcinoma and is rarely recognized before the patient's death.

Few patients with clinically apparent large bowel metastases from small cell carcinoma of the lung have been reported.[10] Pain and/or obstruction are the most common manifestations of large bowel involvement. A single patient has presented with occult gastrointestinal bleeding and is described in the German medical literature.[11] One might speculate that occult bleeding rather than melena would have occurred in our patient if he had not been taking Coumadin each day. Nevertheless, this is currently the only patient with right sided small cell carcinoma of the bowel reported to have presented with melena.

The problem of deciding whether our patient

had an unusual polypoid presentation of a primary small cell carcinoma of the cecum versus an uncommon metastatic deposit from a bronchogenic tumor will not be resolved. We tend to believe the latter possibility is most likely. Unlike most forms of bronchogenic carcinomas, the histiologic appearances of metastatic deposits from primary small cell cancer remain remarkably consistent and are almost identical to the primary lesion.[5] The pathologic samples obtained from the left lung of our patient compared favorably to the malignant cells of the cecal polyp.

Our report is intended to display the unusual biologic behavior of small cell carcinoma. The clinician should be aware that small cell carcinoma of the bowel can be a primary lesion, but is more often an indication to perform a lung survey. We point out that small cell carcinoma may occur in the form of a sessile polyp, although we are unable to state whether this was a primary or secondary lesion.

The highly aggressive nature of this neoplasm insures that distant metastases are virtually always present at the time of diagnosis. The mean survival rate of an untreated patient is 6 months and a 1 year survival is approximately 15%.[12] The importance of recognizing small cell carcinoma rests with the tumor's sensitivity to certain regimens of cytotoxic chemotherapy. Examination for occult fecal blood remains the earliest method to identify the high risk patient.

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The Role of Genetic Counseling in Visually Impaired Adolescents

Joseph H. Hersh, MD; Frank A. Zelko, PhD; B. Womack; Alan S. Bloom, PhD; L. McMartin; L. J. Russell, MD; Bernard Weisskopf, MD

The presence of genetic disorders in a high percentage of adolescents with significant visual impairments emphasizes the important role that genetic counseling can play in this population. However, its intended goals have been controversial. Responses to structured interviews about genetic counseling services from three groups of former students from the Kentucky School for the Blind were compared. One group consisted of students who had received genetic counseling; another, of students who had declined it; and a third, of students who had graduated before the service was available. In all groups, genetic counseling was viewed as a valuable service which would have been pursued by the majority of those who did not have the opportunity to receive it, and by many of those who refused it initially. Although genetic counseling did little to enhance knowledge of the cause of the specific visual impairment, it appeared to be useful in providing information regarding the risk of visual impairment in future offspring. A relatively high rate of unplanned pregnancies was noted in the group who had refused genetic counseling. The significance of this observation is uncertain. One interpretation is that the group refusing genetic counseling may have consisted of individuals who had fewer concerns as adolescents about family planning issues. These observations suggest that it may be appropriate to recommend to adolescents with significant visual impairments to defer childbearing until independent life experiences are accumulated outside the school setting. Then, prior to considering childbearing, genetic counseling should be sought.

It has been estimated that there is a genetic basis for visual deficits in approximately 50% of children and adolescents attending schools for the blind.[1,2] In the future, this figure may actually increase with improved outcome of infants at risk for retinopathy of prematurity.[2] The importance of providing genetic counseling to this population has been emphasized, since matings tend to occur more frequently amongst the blind, resulting in a greater risk for visual loss in offspring of affected individuals.[2,3] The intended goals of genetic counseling services offered to visually impaired individuals have been somewhat controversial. One concern raised has been of the potential use of genetic counseling to negatively influence family planning decisions in visually handicapped populations.[2-5] In some visually impaired individuals, the desire to have a child outweighs concerns regarding the risk that offspring will be similarly affected. Blindness among offspring may be viewed by some visually impaired individuals as less of a burden than it is felt to be by those who are normally sighted. In such cases, there may be a resistance to genetic counseling services which are presumed to be coercive in nature.[4]

The Genetics Unit of the Child Evaluation Center at the University of Louisville School of Medicine provides genetic counseling on an elective basis to graduating high school students attending the Kentucky School for the Blind (KSB). This report presents data obtained from a structured interview designed to assess the impact of genetic counseling through this program. Primary goals of the survey were to determine if and how genetic counseling enhances a student's understanding of his or her visual impairments, and its effect upon reproductive planning.

From the Child Evaluation Center, University of Louisville School of Medicine, and the Kentucky School for the Blind, Louisville, KY.

Presented at the 38th Conference of the American Society of Human Genetics.

Method

Over a 7-year-period, 66 high school students at KSB were offered genetic counseling. Of this group, 29 (43%) elected to pursue the service,

which involved one session in which a family pedigree, medical history, and medical records were reviewed with the propositus, followed by an explanation of the major manifestations and prognosis of the condition, its inheritance pattern, and risk of a similar visual impairment to offspring. In some instances, a second session was needed to review additional information or results of other medical studies.

Structured interviews were developed for the following samples: *Group I*, consisting of individuals who received genetic counseling; *Group II*, comprised of individuals who were offered but refused genetic counseling; and *Group III*, a cohort of students who had attended KSB before genetic counseling services were available. Surveys were conducted by a telephone interview. Eighteen (62%) of the 29 students who received genetic counseling (Group I) consented to an interview, while 11 others from this group chose not to participate in the project. These students were compared to 10 individuals who refused counseling (Group II) and 16 control participants (Group III) who also participated in the interview process. Major issues addressed in the interview included the following: (1) the students' impression of the purpose and perceived value of genetic counseling; (2) knowledge of the student's ocular disorder, including whether it was genetic in origin; (3) reproductive history; and (4) future reproductive plans.

Table 1. Etiology of Ocular Condition of Questionnaire Respondents

Condition	Group I (n = 18)	II (n = 10)	III (n = 16)
A. Genetic			
1. Aniridia	1	1	
2. Anteriar chamber defects	2	1	
3. Charaidaretinal degeneration	4	4	3
4. Calar visian lass	4		
5. Cangenital cataracts	2	1	5
6. Cangenital glaucama			1
7. Cangenital aptic atraphy		1	
8. Leber's optic atraphy	1		
B. Acquired			
1. Antenatal infection			1
2. Pastnatal infectian		1	
3. Retinapathy af prematurity	2	1	5
4. Trauma	1		
C. Unclassified	1		1

At the time of the interview, 55% of the respondents were single and 45% were married or cohabiting. Thirty-six percent had some college experience or were currently attending college, and 4% had completed graduate or undergraduate degrees. Thirty-six percent were students at the time of the survey, 25% were employed, 14% were housewives, and 25% were unemployed.

Interview responses of participants in the three groups were utilized to obtain descriptive feedback regarding the students' genetic counseling experience. Selected group comparisons were conducted using chi-square analyses. Primary comparisons were between Groups I and II, which were of equivalent age (M = 21.5 years, SD = 2.4 and M = 22.2 years, SD = 2.2, respectively). Selected comparisons were also drawn with Group III, which was significantly older than the other groups (M = 29.6 years, SD = 3.1). Gender did not vary significantly among the groups, which together were comprised of 25 males and 19 females. Furthermore, the etiologies of respondents' visual deficits did not vary by group (see Table 1).

Results

Perceived Value of Genetic Counseling Services

In response to questions addressing the perceived value of genetic counseling, 60% of Group II participants, ie, refused genetic counseling, stated that they would not have declined genetic counseling again if they had been given another opportunity to receive it. Fifty-six percent of Group III respondents, ie, not offered genetic counseling, felt that genetic counseling would have been useful to them, and 69% of the same group stated that they would have used such a service had it been available when they were students. Individuals who received genetic counseling, ie, Group I, expressed satisfaction with the information it provided them, giving it a mean rating of 5.9 (SD = 1.3) on a 7-point scale which ranged from 1 = "not at all" to 7 = "very much," indicating how valuable they had found it to be. Thirty-nine percent of the counseled group reported that they had received useful information about the disease which caused their visual impairment. Sixty-seven percent said that they had received valuable information about their risk for having children with a visual impairment. Ninety-four percent of those counseled reported that they would have pursued genetic counseling again.

Knowledge about Genetic Counseling, their Visual Impairment, and its Heritability

Those counseled cited appropriate reasons for seeking genetic counseling. Eighty-nine percent of these patients in Group I who participated in the study reported that they had pursued genetic counseling to learn more about the genetic basis of their visual disorder. Fifty-six percent stated that they had done so to learn more about their visual impairment. Fifty percent cited reasons specifically related to family planning.

Using chi-square analyses, comparison of the questionnaire responses of Group I students with those of Group II and III individuals did not appear to reflect group differences in the accuracy of knowledge prior to genetic counseling about the following: (1) their medical diagnosis, (2) whether their visual impairment had a genetic basis, and (3) the specific risk of having affected offspring when asked to choose among risks of <1%, 2-5%, 25% or 50%. Furthermore, genetic counseling did not appear to have a significant impact on the knowledge of individuals regarding their diagnosis or whether or not their condition was genetic as determined from chi-square comparisons of Groups I and II.

Overall, 63% of the respondents in Groups I and II reported their diagnosis accurately in the telephone interviews. Similarly, 80% knew correctly whether or not their condition was inherited. However, counseled individuals were significantly more knowledgeable about the specific risk to their offspring for having a similar visual impairment, chi-square (1) = 5.04, $p = .025$. Of the respondents in Group I, 12 of 18 (67%) accurately reported the correct risk to their offspring, while only 20% of those in Group II were able to do the same.

Reproductive Patterns

Though a small size prevented formal analysis of data regarding reproductive patterns, informal inspection suggests a possible association between genetic counseling and patterns of childbearing. Overall, 11 of the 44 respondents (25%) had children, including 3 of 18 (17%) Group I individuals, 4 of 10 (40%) Group II individuals, and 4 of 16 (25%) Group III participants. Ten of the 11 respondents with children reported that one or more of their pregnancies had been unplanned. Interestingly, 8 of those 10 had not received genetic counseling. Of further interest is the fact that 6 of these 10 childbearing individuals carried a high risk for having a similarly affected offspring (ie, 25% or greater).

Discussion

The current data reinforce the role of genetic counseling as a useful service for individuals who have severe visual impairments. During the study period, fewer than half the students at KSB elected to pursue genetic counseling while in their high school years. Interviews of these individuals years later, however, indicated that a higher level of interest in genetic counseling services was apparent, with about two-thirds surveyed expressing a desire to receive genetic counseling. These findings emphasize the role that timing may play in providing this service, and suggest that access to genetic counseling services should be facilitated throughout the young adult period in this population.

Those seeking genetic counseling seemed to do so for appropriate reasons including gaining additional information about their condition, determining whether their disorder was inherited, and learning about the risk to offspring. Most of the respondents seemed fairly knowledgable about their visual impairment, and genetic counseling did not appear to enhance their awareness of the diagnosis or their understanding of whether or not the condition was genetic. It would appear that by high school age such information typically had been made available to KSB students. However, counseling appeared to significantly enhance participants' understanding about their specific risk of having a similarly affected offspring. In the current sample, genetic counseling seemed to serve best the primary purpose for which it was intended, ie, providing detailed information about the genetic nature of participants' visual impairments, and particularly information which could be of use in making reproductive decisions.

The current data also raise the possibility that an association between seeking genetic counseling and childbearing decisions may exist. Nearly one third of the 26 individuals in Groups II and III not receiving counseling had reproduced at the time of the interview, compared to nearly one half that number in the counseled group. In all three groups, a high proportion of pregnancies were unplanned. It is tempting to speculate that the higher percentage of childbearing in Group II individuals may have been the result of their failure to obtain specific risk information through

genetic counseling. Alternatively, this finding may reflect in part a relative lack of concern about future reproductive planning among members of Group II when they are high school students. Support for such an interpretation can be drawn from the fact that a majority of Group II respondents expressed a willingness to pursue genetic counseling, if given a second opportunity, at a later age, at which time it would more directly influence reproductive planning decisions. This observation would suggest that one prudent approach to an initial genetic counseling session, as previously outlined by Harper and Vowles,[4] might involve encouraging the visually impaired individual to defer childbearing until independent life experiences are accumulated outside of the sheltered high school setting, and that genetic counseling be sought again prior to the decision to start a family.

Though the current data are limited by a small sample size, they suggest some directions for future research. Subsequent investigations should attempt to study prospectively and longitudinally the impact and timing of genetic counseling in a visually-impaired population. Studies directed at these issues will hopefully help to determine how genetic counseling services may be used effectively to enhance the quality of life of visually-impaired individuals.

ACKNOWLEDGMENTS: We are grateful to Jane Bradley, Carolyn Goatley, and Sherry Stansbury for their assistance in this project.

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"That's Not My Dog"

"Sad to say, it is the physician who will be "final common pathway" of patient malcontent. Yet the physician will have no input into constructing this new health care reform, that is currently called "Health Security Act.""

Let me be sure to get it straight. It is a Peter Sellers' classic. He is again playing Inspector Clouseau, a bumbling, inept detective, in a Pink Panther movie sequel. The scene takes place at a hotel check-in desk where Inspector Clouseau is to be a guest.

As Peter Sellers is signing the registration card he looks down and sees an unpleasant looking dog lying on the floor. Rather casually he asks the registration clerk, "Does your dog bite?" The clerk answers, "No."

Whereupon Inspector Clouseau bends down to pet the animal, and the dog responds with a snap and bites the hand of the detective. Clouseau jumps back holding his injured hand, and looking bewildered, says to the room clerk, "I thought you said your dog doesn't bite." The clerk responds, "That's not my dog."

I fear a repeat scenario is just waiting in the wings for American medicine and it's receptive public. As the many diverse political camps rush inexorably toward some kind of health care change and perhaps compromise, the collective patient stands on the outside with nose pressed against the window, hoping "it won't bite."

Sad to say, it is the physician who will be "final common pathway" of patient malcontent. Yet the physician will have no input into constructing this new health care reform, that is currently called "Health Security Act."

That reassuring word "security" rings an ominous sound. Remember Social Security? That was to be the New Deal safe haven from the 1930s that has turned into an insatiable glutton of the 1990s. It is going broke. Remember Medicare? That was to be The Great Society equalizer for medical care for the elderly. It is going broke. Remember the Farm Subsidy Program? Well, you see my point as the list grows on.

Just who are the villains, the victims, and the good guys? Are they the Congress, the past and current presidents, the insurance companies, the public and patients, the doctors, the hospital administrators, the lawyers? They all seem to be milling around out there together and it is hard for this old sniper to put his cross-hairs on one without mowing down a few innocents along the way.

What am I trying to say here? It is simply that after 200 or so years of fee-for-service and some charitable care, we are moving in less than one generation toward universal health care paid for by government mandate. That is hardly the American free enterprise system. Current medical care in the United States is excellent not so much because the physicians are better trained, although that may be part of it, but rather because of the ancillary diagnostic and therapeutic gear that is available. This plus the fact that there is little or no waiting period to use this gear. With universal care and the rationing it will involve, it will be "take a number and take a seat."

Like all government programs be they small or large, once they are in place there is no turning back. In fact they seem to grow and take on a life of their own as the bureaucratic management begins to metastasize.

So colleagues, gird your loins and dare your best. Remember it is the patient we serve and not the government. "Our" dog truly shall not bite.

Milton F. Miller, MD

AWARDS NOMINATIONS

The KMA Awards Committee is accepting nominations for the two highest awards the Association presents. The Distinguished Service Award is presented annually to a member of the Association based on the following criteria:

- Contributions to organized medicine (including membership in county society, attendance of county and state meetings, service on committees, leadership as an officer, etc.)
- Individual medical service
- Community health, education and civic betterment
- Medical research

The nominee may qualify on any one or all combinations of these points. Reasons for the nominations should be clearly stated.

The Kentucky Medical Association Award is presented to an outstanding lay person in Kentucky each year in honor of his or her outstanding accomplishments in the field of public health and/or medical care.

The Awards Committee will have the responsibility to choose recipients of the KMA Distinguished Service Award and the Kentucky Medical Association Award. Any county society or individual member may suggest nominees to the committee.

The awards are presented at the President's Luncheon during the annual meeting.

AWARD NOMINATION FORM

Name: _____

Address: _____

Birth Date: _____ Place: _____

Marital Status: _____

Spouse's Name: _____

Children: _____

☐ Distinguished Service Award (Physician)

☐ KMA Award (Lay Person)

Education: _____

Military: _____

Membership in Professional Organizations: _____

Membership in Civic Organizations: _____

Honors and Awards: _____

(Describe nominees qualifications and other pertinent information which the Awards Committee may consider in making its decision.

Name of Person or Group Submitting Nomination: _____

Address: _____

Phone: (Home) _____

(Office) _____

Please fill in and mail to: KMA, Attn: Awards Committee, 301 N Hurstbourne Pky, Ste 200, Louisville, KY 40222

Deadline for receiving nominations is July 15.

Kentucky Medical Association Alliance Annual Convention April 18-19



Gloria J. Griffin

All roads lead to Louisville as the membership of the Kentucky Medical Association Alliance gathers for its 72nd Annual Convention. We meet annually to celebrate the culmination of our members' efforts as we plan for the future of the Alliance. The Jefferson County Alliance is anxiously awaiting your visit to our beautiful city and the Seelbach Hotel.

Members are invited to attend all sessions on Monday or Tuesday. The Monday afternoon sessions are designed to inform and educate you about the state and national organization. The House of Delegates meeting scheduled for Tuesday morning will allow you the opportunity to review the progress of the statewide issues and projects. County presidents will be reporting on the activities of their county members, with each county's successful projects and programs being highlighted. Collectively, our members continue to support the future of medicine through their participation in the American Medical Association Education Research Foundation (AMA/ERF), the Ephraim McDowell House in Danville, Kentucky's Ronald McDonald Houses, and the Health Careers Fund for students embarking on a career in the allied health care field.

Our Convention guests will be Colleen Adam, AMAA Field Director, and Jo-Ann Daus, SMAA President-Elect. They will participate in the Monday sessions and the House of Delegates meeting on Tuesday.

Dr Ardis Hoven will be our guest speaker at Tuesday's luncheon. The past presidents of the KMAA will be recognized at the luncheon, after which the awards for AMA/ERF, Doctors' Day, Membership, and the President's Awards will be presented. AMA/ERF checks will be presented to the Medical School Deans from the University of Kentucky and University of Louisville. The finale will be the installation of the 1994-95 KMA Alliance officers by our AMAA guest, Colleen Adam.

President
Joyce Clark, Pulaski County
President Elect
Marla Vieillard, Boyd County
AMA/ERF Vice President
Debbie Bruenderman, Jefferson County
Health Promotion Vice President
Nancy Swikert, MD, Northern Kentucky
Legislative Affairs Vice President
Diana Moore, Fayette County
Membership Vice President
Barb Haas, Northern Kentucky
Recording Secretary
Marna Loucks, Daviess County
Treasurer
Betty Housman, McCracken County

"It has been an honor and privilege to serve as the 69th President of the KMAA."

The KMA Alliance needs the financial support of all physician spouses in Kentucky. The commitment of our members is evident in the projects we are able to accomplish, but the KMA Alliance could accomplish more for organized medicine by just increasing its dues paying membership. The membership committee has made every effort to seek out potential members throughout the state. Numerous contacts were made to encourage these spouses to join as Members-at-

Calendar of Events

SUNDAY, APRIL 17, 1994 (Eastern Standard Time)

6:00 PM- 9:00 PM	KMAA Hospitality Suite Open — light supper provided

MONDAY, APRIL 18, 1994

7:30 AM–2:00 PM	Hospitality Suite Open for Delegates Registration
9:30 AM–1:30 PM	Committee Meetings in Gold Room, 2nd floor
9:30 AM	Planning/Membership Committees
11:30 AM	Finance Committee
12:30 PM	Executive Committee
2:00 PM–2:30 PM	Pre Convention/to discuss proposed Budget for 1994-95
2:30 PM–4:30 PM	Transition/Leadership Meeting 93/94 & 94/95 Board This is an open leadership training meeting for all state and county officers and chairmen. Grand Ballroom, 10th floor
6:30 PM	Reception honoring Joyce Clark at the home of Dr and Mrs David Bruenderman, 326 Mockingbird Hill Road, followed by Dinner Honoring the 1993-94 Board of Directors. The Hospitality Suite will be open after dinner.

TUESDAY, APRIL 19, 1994

7:30 AM–8:45 AM	Hospitality Suite Open — Brown Forman Suite
8:00 AM–9:00 AM	Delegate Registration in Grand Ballroom Foyer, 10th floor
9:00 AM	KMA Alliance House of Delegates
12 NOON	Luncheon in Honor of Past State Presidents, Special Awards and Installation of 1994-95 KMA Alliance Officers, Rathskeller, Lower Lobby
2:00 PM	1994 & 1995 Joint Nominating Committee, Brown Forman Suite
2:30 PM	Post Convention Board Meeting, Grand Ballroom

For more information regarding fees and reservations, call Alice Cowley, (502) 896-6049.

THIS IS AN OPEN MEETING FOR ALL KMAA MEMBERS

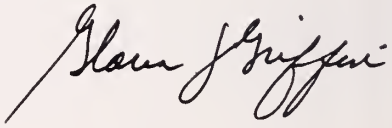
Large. Additional membership efforts were extended to the medical students and resident spouse programs through the KMAA "Sponsor a Spouse Program."

Legislation has been of special interest with Health System Reform being the "hot topic" in the state and national arena this year. The KMA phone bank, manned by Alliance members from Fayette County, was instrumental in activating physicians across the state on impending legislative issues. The KMAA "Legislative Call to Action" was issued on March 1 to physician spouses asking them to activate their county phone banks, to alert area physicians of the importance for all to become involved in the health system reform process.

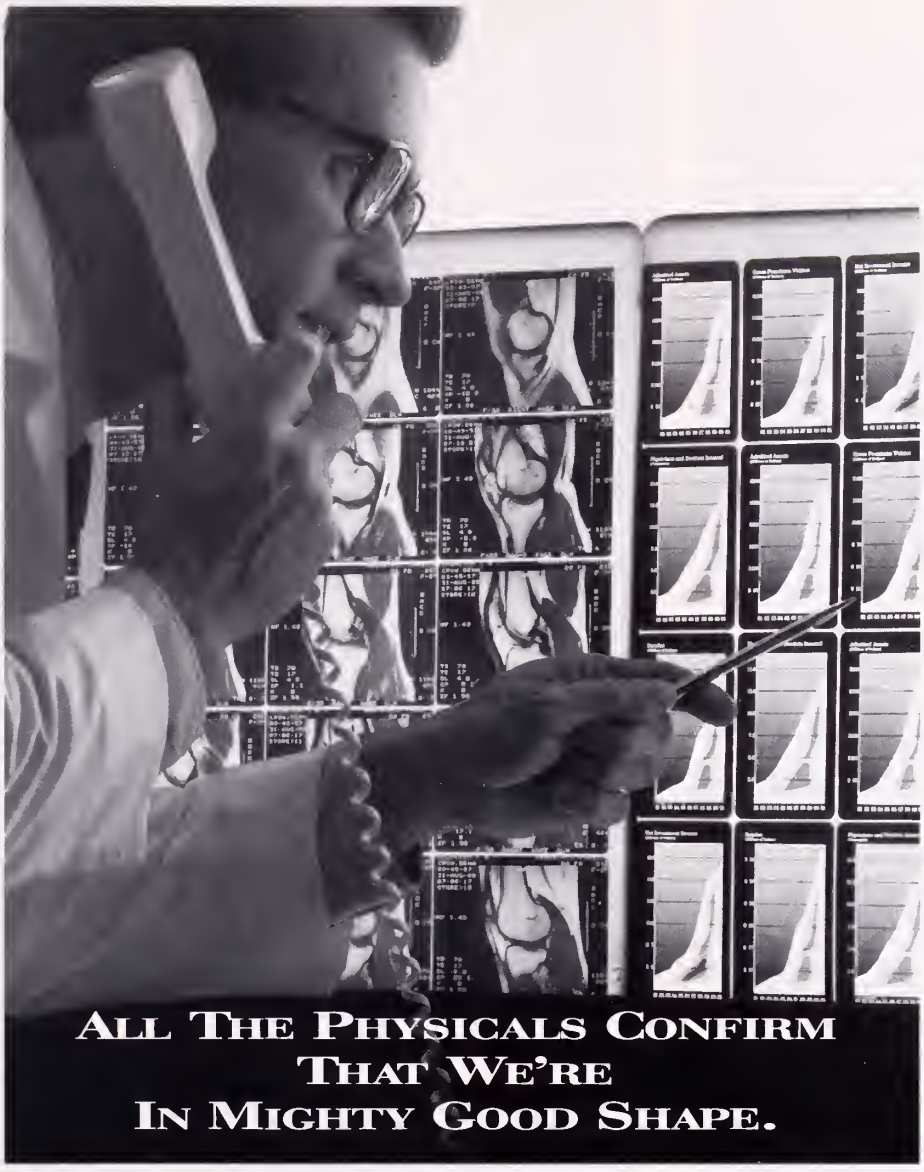
I appreciate the encouragement and continued support the Alliance has received from KMA leadership and staff as we have worked together to achieve the KMA Alliance mission "to work in coalition with KMA to promote quality health care and sound legislation."

The 1993-94 year has been a busy year for the family of medicine. A year ago, I challenged each of you to commit to the medical profession with the same dedication as your spouse, and to serve that commitment by urging significant activities by your Alliance at the local, state and national levels, and to become involved in those efforts.

It has been an honor and privilege to serve as the 69th President of the KMAA. It is because of the care and compassion that my husband Larry showed for his patients and his continued dedication to organized medicine that I became involved and will continue to stay involved in the county, state, and national organizations for physician spouses.



Gloria J. Griffin
1993-94 KMAA President



ALL THE PHYSICALS CONFIRM THAT WE'RE IN MIGHTY GOOD SHAPE.

Examine our performance and you'll agree. Membership was up again last year, passing 15,000. Total premiums written surpassed $150 million. Policyholders' surplus in excess of $50 million. Healthy numbers, confirmed by insurance auditors, and an A.M. Best Rating of B+(Very Good). We have a strong financial position, increasing market share and competitive pricing. A solid foundation for your future. For more information, call us at 1-800-228-2335.

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1994 KMA Legislative Seminar

Over 75 Kentucky physicians attended KMA's Legislative Seminar in Frankfort on February 24. Those in attendance heard the latest on health system reform from Senator John "Eck" Rose, President of the Senate, and Representative Joe Clarke, Speaker of the Kentucky House of Representatives. Both Senator Rose and Speaker Clarke were frank and open in their discussion of health system reform and issues such as the provider tax and rate setting. Attendees also heard from Senator John Rogers (Somerset) about SCS for SB 97 and Representative Bill Lear (Lexington) regarding the future of the General Assembly.

Also on the program were Ardis D. Hoven, MD, President of KMA, and Robert R. Goodin, MD, President-Elect. Dr Hoven spoke on the physician's role in health system reform, and Dr Goodin spoke on tort reform.

After the seminar, many of the attendees went to the Capitol and met with their Legislators to discuss issues of concern to Kentucky physicians. It cannot be overemphasized — **YOUR PARTICIPATION AND INVOLVEMENT IN THE LEGISLATIVE PROCESS ARE ESSENTIAL.** While KMA leadership and staff routinely meet with Legislators to represent your interests, **NOTHING IS MORE EFFECTIVE THAN COMMUNICATION FROM A CONSTITUENT — YOU!!**

GET INVOLVED — YOU CAN MAKE A DIFFERENCE. KMA

Photos top to bottom: Left, Wally O. Montgomery, MD, Chair, KMA Committee on State Legislative Activities; Donald R. Stephens, MD, Chair, KMA Board of Trustees. Below, an intensely interested audience. Right, Senator Nicholas Kafoglis, MD; John A. "Eck" Rose, President of the Senate; Representative Bob M. DeWeese, MD, and Gloria Griffin, KMA Alliance President.





















Above, top to bottom: Robert R. Goodin, MD, KMA President-Elect; William P. VonderHaar, MD, KMA Secretary-Treasurer; Representative Bill Lear. Right: Ardis D. Hoven, MD, KMA President; Senator John D. Rogers, Senate Minority Floor Leader; Joe Clarke, Speaker of the House.

PEOPLE

Chandra M. Varia, MD, Martin, estimates that she has delivered about 3,400 babies during her 14½ years as an OB/GYN in Floyd County. After recently deciding to concentrate solely on gynecology, she bid farewell to her obstetrics practice by hosting a large party in honor of all the children she had delivered.

For the unique reunion, appropriately named "A Celebration of Children," Dr Varia extended an invitation via the local news media to the families of children she delivered at two hospitals: Our Lady of the Way in Martin and Highlands Regional Medical Center in Prestonsburg.

The climax of the event was the announcement by Dr Varia and her husband Mahendra Varia, a veterinarian in Martin, that they are setting up a $25,000 endowment at Prestonsburg Community College and the University of Kentucky. The interest from the fund will be used to provide college scholarships for children Dr Varia delivered.

This is not the first scholarship fund the Varias have endowed. In 1990, they pledged $100,000 to Prestonsburg Community College to be used for the college's nursing program, for student scholarships, and for emergency loans to needy students.

Joseph S. Sanfilippo, MD, has been elected president of Alliant Adult Services, Louisville. **Fred A. Williams Jr, MD,** is president-elect; **Mary Ann C. Henry, MD,** is secretary-treasurer. Members-at-large are **David A. Casey, MD,** and **Lawrence A. Schaper, MD. Robert W. Shaw, III, MD,** is past president.

Sue A. Cutliff, MD, has been elected president of the Kosair Children's Hospital Medical Staff. **Diller B. Groff, MD,** is president-elect and **James M. Hinkebein, MD,** is secretary-treasurer. New members-at-large are: **David H. Adamkin, MD; Cynthia G. Nassim, MD;** and **Dale M. Roberts, MD. Toni M. Ganzel, MD,** is past president.

Russell A. Williams, MD, recently received a 3-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at Jewish Hospital, Louisville. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons.

David H. Adamkin, MD, professor in the Department of Pediatrics at U of L School of Medicine, received the Outstanding Leadership and Service Award for 1993 from the Kentucky Perinatal Association.

David C. Dolen, MD, has been appointed vice president and medical director of Our Lady of Peace Hospital in Louisville. He assumes the position left vacant by the resignation of **J. David McNeely, MD,** who remains on the hospital's medical staff. Dr Dolen will continue to serve as clinical director of the Child/Adolescent Partial Hospitalization Program. **Charles F. Francke, MD,** assumes Dr McNeeley's former post as clinical director for Adult Treatment Services. Dr Francke will stay on as clinical director of the Geriatric Treatment Services Unit.

Larry N. Cook, MD, acting chairman, Department of Pediatrics at U of L School of Medicine, received the Lawrence-Grever Award from the U of L Student Government Association. The annual award honors student government alumni who have made a significant contribution to the community.

UPDATES

Mission to China Project

Physicians, dentists, and nurses are being recruited by the Christian Medical Association (CMA) to provide free medical, dental, and surgery services for their China Project from September 10 to 25, 1994.

This CMA trip is by a first-time invitation from China's communist government. The volunteer medical missions team will help 10 village clinics per day and refer people to surgery and follow-up in local hospitals. Bejing and Shanghai hospitals will also be visited on the trip.

The CMA, which has 30 years experience conducting short-term medical missions, will provide all training and administration. For more information or to donate funds for medicine, contact CMA, PO Box 3501, Seal Beach, CA 90740, or call 310/592-3971.

U of L School of Medicine Promotes Ethics

The University of Louisville School of Medicine has taken several steps to ensure that students learn about the importance of ethics in medicine.

Established in memory of a former U of L professor and designed to help family doctors carry on a heritage of humanity and ethics in their practices, the Department of Family and Community Medicine has established the **William Ray Moore Chair.**

Additionally, in the department, there is a Division of Humanism in Medicine, directed by assistant professor **Marc C. Newman, MD,** through which medical students and residents are taught ethics courses, such as "Humanistic Medical Interviewing," "Family Practice Clerkship," and "Bioethics."

Also, the School of Medicine has an ethics committee, which deals primarily with faculty ethics issues.

The most recent effort to promote ethics comes from Mim Stambaugh, who established the **James L. Stambaugh, Jr, MD, Lectureship** in honor of her late husband. Dr Stambaugh, an ophthalmologist, was an alumnus of U of L's School of Medicine, graduating second in his class in 1948 at the age of 21.

Mim Stambaugh hopes this lectureship will educate practitioners and students about the need for ethics and humanity in medicine, and that her gift will encourage others to follow her lead in promoting this endeavor.

Leadership Summit on Breast Cancer

The Kentucky Cancer Program has announced that "The Kentucky Leadership Summit: The Challenge of Breast Cancer" will be held on Wednesday, May 18, 1994, in Louisville at the Brown Hotel. The goal of the summit is to raise awareness of the importance of worksite initiated breast cancer education and screening programs. Several model worksite health programs have been established in Kentucky and will be highlighted. Community resources available to assist employers in establishing worksite programs will also be discussed. For more information, call 1-800-4-CANCER.

Mandatory Continuing Medical Education

As of January 1, 1994, state regulation 201 KAR 9:310 — mandatory CME requirements for physicians — became effective. The regulation, which is implemented through the Kentucky Board of Medical Licensure, requires all physicians holding a Kentucky license to complete a minimum of 60 hours of continuing medical education every 3 years. Thirty of the 60 hours must be in Category 1 educational activities, and 2 hours must be in HIV/AIDS courses approved by the Cabinet for Human Resources.

The Kentucky Board of Medical Licensure may grant an extension of time (but no exemption or waiver) to a physician who, for sufficient cause, has not yet completed the requirements of the regulation. Any licensee failing to complete the CME requirements on time, or who fails to receive an extension of time, shall be fined a minimum of $200 and allowed 6 months to come into compliance. If after 6 months the licensee is in noncompliance, his/her license will be suspended until verifiable evidence is submitted indicating completion of the requirements.

Questions about implementation of the regulation should be directed to the Kentucky Board of Medical Licensure at 502/429-8046.

New CME Provider Policy Manual Published

KMA has recently published a provider manual, *The Accreditation Program of Continuing Medical Education in Kentucky*, to assist individuals who plan and offer continuing medical education activities. The Manual provides general information on continuing medical education such as the mandatory CME requirements for physicians tied to licensure, counting of CME credit hours, and accreditation statement requirements. The Manual also provides more specific information on the accreditation process, types and duration of accreditation, and the costs associated with the accreditation process. Also included in the Manual are the KMA Essentials and Guidelines, KMA Standards for Commercial Support, and the AMA Guidelines on Gifts to Physicians from Industry. One new addition to the Manual is a preliminary questionnaire for organizations considering application for accreditation. The CME Committee now requires that the questionnaire be filled out and sent to the KMA Headquarters before an application is submitted. This allows the opportunity for the KMA to assist organizations who are interested in becoming accredited without having to take time to fill out the full application. No fee is involved in submitting the preliminary questionnaire.

CME Credit vs CME Accreditation

The terminology involved in CME is easily confused. On numerous occasions, the phrase ". . . this program is accredited for 1 hour of CME . . ." has appeared in promotional materials for continuing medical education programs offered in Kentucky. This phrase is incorrect since conferences, symposia, grand rounds, seminars, etc, are *not accredited.* Only an *organization* is accredited and may *designate* an activity to qualify for CME credit (ie, AMA/PRA Category 1 credit). An organization does not accredit any CME activity.

With respect to designating an activity for CME credit, many CME providers do not understand that the AMA has control over CME Category 1 and 2 credit and has "tied" CME credit under the AMA/PRA to the national system of accreditation which represents a unilateral decision by the AMA. The KMA, through recognition by the Accreditation Council on Continuing Medical Education (ACCME), has been given the ability to accredit organizations, but there is not anything related to accreditation by the ACCME or KMA which gives an accredited sponsor of CME the *authority* to designate CME activities for credit under the AMA/

PRA. An accredited sponsor may designate Category 1 AMA/PRA credit because it is accredited and because the AMA extends the privilege of designating AMA/PRA credit to accredited sponsors of CME.

CME Committee

The Committee and Council on Continuing Medical Education met jointly on Wednesday, February 9. The CME Committee accredited three organizations to provide continuing medical education programs. Accredited were Jewish Hospital, the Trover Clinic Foundation, and the Boyle County Medical Society/ Ephraim McDowell Regional Medical Center Consortium. The Committee also approved a new policy and procedure manual for all organizations accredited by the KMA, and set May 26, 1994, as the date for the 4th Annual CME Seminar.

Sports Medicine Symposia

The Committee on School Health, Physical Education, and Medical Aspects of Sports met on January 27 and scheduled 11 Sports Medicine Symposia for Coaches for the spring and summer of 1994. Kentucky Department of Education regulations require high school athletic team coaches to attend a biennial symposium. The Committee will issue each coach in attendance at the 1994 Symposia an updated "Syllabus of Sports Injury Care." A second printing of the Syllabus was made possible by a grant from the Upjohn Company.

KMA-RPS

The KMA Resident Physician Section Governing Council met on February 15 to elect 1994 officers. The results are as follows: President — **Judy Linger, MD,** (UK); President-Elect — **Robin Floyd, MD** (UL); Chair — **Greg Fuqua, MD** (Trover); AMA-RPS Delegate — **Todd Prewitt, MD** (St. Elizabeth's); AMA-RPS Alternate — **Pradip Patel, MD** (UL); KMA Delegate — **Donna Skinker, MD,** (UK); KMA Alternate — **Mehmet Akaydin, Jr, MD,** (UL); Secretary/ Treasurer — **Gay Fulkerson, MD** (Trover).

The Council reviewed the AMA/ RPS Interim Meeting activities, and will meet April 19 to finalize resolutions for the Annual Meeting.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Allen

Cecil E. McMurtry, MD — EM
323 Bandy Rd, Holland 42153
1961, U of Tennessee

Boyd

Wendell L. Bailey, MD, — S
PO Box 1865, Ashland 41105
1988, U of Louisville

Viorel Boborodea, MD — OBG
2245 Winchester Ave #1, Ashland 41101
1988, New York Medical College

Ann W. Craig, MD — PD
2419 Lexington Ave, Ashland 41101
1985, Medical College of GA

Daviess

Elizabeth Ottman, MD — OBG
815 E Parrish Ave #330, Owensboro 42303
1989, Northeast Ohio Col of Med

Fayette

J. S. Adams, MD — D
807 S Limestone, Lexington 40508
1977, U of Michigan

Neil C. Armstrong, MD — AN
4030 Tates Creek Rd #1145, Lexington 40517
1986, Emory

Paul Bachner, MD — PTH
810 Delong Rd, Lexington 40515
1963, Columbia

Lisa T. DeGnore, MD — ORS
4030 Tates Creek Rd #1135, Lexington 40517
1986, U of Michigan

David B. Drake, MD — PS
3900 Crosby Dr #203, Lexington 40515
1983, U of Kentucky

Robert M. Futoran, MD — PTH
135 E Maxwell #401, Lexington 40508
1988, Chicago Medical School

Richard J. Glassock, MD — IM
UKMC — KY Clinic #J525, Lexington 40536
1960, UCLA

Pamela E. Harris, MD — AN
3320 Tates Creek Rd, Lexington 40502
1988, Med Col of Alabama

Stewart S. Leong, MD — PTH
PO Box 1921, Lexington 40593
1981, U of California, Davis

Ron P. Linehan, MD — AN
4132 Springwater Dr, Lexington 40515
1989, U of Tennessee

Robert B. Nickerson, MD — PMR
2050 Versailles Rd, Lexington 40504
1989, Med Col of Georgia

James C. Reed, MD — R
UKMC — Diag Rad, Lexington 40536
1968, U of Miami

Yvonne A. Satterwhite, MD — ORS
601 Perimeter Dr, Lexington 40517
1987, Tulane

Steven C. Solvik, DO — AN
1800 Nicholasville Rd #104, Lexington 40503
1989, Kirksville Col of Osteopathy

Henderson

John A. Price, MD — AN
910 Craig Dr, Henderson 42420
1976, Hahnemann

Jefferson

Karen W. Bibb, MD — PD
6702 New Bethany Rd, Charlestown, IN 47111
1987, U of Louisville

Carl D. Coppola, MD — OTO
5115 Forrest Grove Pl, Prospect 40059
1986, Loyola

Marianne H. Cowley, MD — OPH
4130 Dutchmans Ln #201, Louisville 40207
1982, Albany Medical Col

Kim E. Goldman, DMD — DENT
1169 Eastern Pky #2265, Louisville 40217

Pamela S. Grim, MD — EM
1 Audubon Plaza Dr, Louisville 40217
1984, U of Washington

Christopher L. Hellman, MD — AN
414 Meridian Ave, Louisville 40207
1989, U of Texas, Houston

Stewart C. Hoertz, MD — R
210 E Gray St #1003, Louisville 40202
1988, U of Louisville

George M. Kushner, MD — S
UL School of Dentistry, Louisville 40292
1991, Med Col of Alabama

Steve R. Merta, MD — OBG
210 E Gray #802, Louisville 40202
1989, New York Med Col

Barry H. Miller, MD — AN
1823 State St, New Albany, IN 47150
1989, Indiana U

Vicki L. Montgomery, MD — PD
2301 Cypress Pt, Jeffersonville, IN 47130
1985, U of Kentucky

Bruce A. Scott, MD — OTO
225 Abraham Flexner #401, Louisville 40202
1987, U of Texas, Galveston

Diana J. Thomas, MD — AN
1002 Holly Springs Dr, Louisville 40242
1986, U of Louisville

Jonathan W. Weeks, MD — OBG
601 S Floyd #307, Louisville 40202
1984, U of Kentucky

Northern Kentucky

Robert A. Grober, MD — FP
3104 Dixie Hwy #204, Covington 41018
1982, George Washington U

In-Training

Fayette

James R. Farrage, Jr, MD — PMR

Jefferson

Cem Akin, MD — IM
Marcos F. Barnatan, MD — S
Ardyle C. Cagata, MD — IM
Marcia D. Ebbs, MD — FP
Susan C. Hawkins, MD — PD
Sharon L. Lojun, MD — OBG

DEATHS

Raymond A. Ohler, MD
Corbin
1913-1993

Raymond A. Ohler, a retired general practitioner, died December 27, 1993. A 1939 graduate of the University of Louisville School of Medicine, Dr Ohler was a life member of KMA.

Gregario F. Veza, MD
Elizabethtown
1947-1994

Gregario F. Veza, MD, an anesthesiologist, died January 25, 1994. Dr Veza was a 1977 graduate of the University of Santo Tomas, Philippines, and an active member of KMA.

Hugh P. Adkins, MD
Louisville
1914-1994

Hugh P. Adkins, MD, a retired obstetrician-gynecologist, died February 16, 1994. A 1941 graduate of the University of Louisville School of Medicine, Dr Adkins was a life member of KMA.

Harold Q. Davis, MD
Louisville
1926-1994

Harold Q. Davis, MD, a retired radiologist, died February 22, 1994. Dr Davis was a 1952 graduate of the University of Louisville School of Medicine and a life member of KMA.

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KEMPAC Elects Officers for 1994

KEMPAC officers elected for 1994 are as follows:

James D. Crase, MD	Chairperson
William P. VonderHaar, MD	Vice Chairperson
Wayne W. Kotcamp, MD	Treasurer
Preston P. Nunnelley, MD	Assistant Treasurer
G. Irene Minor, MD	Secretary

The members of the KEMPAC Board of Directors are your representatives and encourage you to discuss political activity in your local area with them.

The districts and directors are:

First Congressional District
Harry Carloss, MD — 225 Medical Center Dr, Paducah, KY 42003
Dan Miller, MD — 312 S 8th St, Murray, KY 42071

Second Congressional District
John Downing, MD — 1403 Andrea St, Bowling Green, KY 42104
Albert Joslin, MD — 1001 Center St, Owensboro, KY 42301

Third Congressional District
Wayne Kotcamp, MD — Ste 200, 601 S Floyd St, Louisville, KY 40202
William VonderHaar, MD — 1170 E Broadway, Ste 400, Louisville, KY 40204

Fourth Congressional District
Kenneth Hauswald, MD — PO Box 1865, Ashland, KY 41101
Vacant

Fifth Congressional District
James Crase, MD — 602 Clifty Rd, Somerset, KY 42501
William Pratt, MD — Medical Arts Bldg, London, KY 40741

Sixth Congressional District
Irene Minor, MD — PO Box 4010, Berea, KY 40403
Preston Nunnelley, MD — 2620 Wilhite Dr, Lexington, KY 40503

Represent KMA Alliance
Mrs Kenneth Gerson (Alberta) — 836 Cahaba Rd, Lexington, KY 40502
Mrs Joseph Haas (Barbara) — 36 Rio Vista Dr, Ft. Thomas, KY 41075
Mrs Donald Neel (Faye) — 3 Stone Creek Park, Owensboro, KY 42303

Exofficio Members
Donald C. Barton, MD — Doctors' Park, Corbin, KY 40701
Wally O. Montgomery, MD — PO Box 7329, Paducah, KY 42001
S. Jerry King, MD — Professional Association Bldg, Pikeville, KY 41501

_____ YES, I wish to become a KEMPAC/AMPAC member.
_____ $100 Physician _____ $100 Spouse _____ $10 Resident _____ $10 Student
Personal check enclosed _____ Charge to my credit card ____ Visa ____ Master Card

_____
Credit Card No. Expiration Date

Signature _____

If your practice is incorporated, KEMPAC and AMPAC voluntary political contributions should be written on a PERSONAL CHECK, not a PSC check. Contributions are not limited to the suggested amount. Neither the AMA nor the KMAA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions.

A portion of voluntary political contributions will be used in connection with Federal elections and are subject to the prohibitions and limitations of the Federal Election Campaign Act. Contributions are not tax deductible.

RATES AND DATA

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Deadline: First day of month prior to month of publication.

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1994 Annual Meeting

Commonwealth Convention Center, Louisville, KY
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1994

APRIL

21-22 — Functional Endoscopic Sinus Surgery Workshop 1994, Nashville, TN. Sponsored by Vanderbilt University Medical Center. Contact: Sherri Culp, 615/322-4030.

23 — First Annual Meeting of the American Society of General Surgeons, The Washington Hilton Hotel and Towers, Washington, DC. Contact: American Society of General Surgeons, 2122 Grove, Glenview, IL 60025-2820, 708/998-4570.

26 — Laser Assisted Uvulo-Palatoplasty — A New Treatment for Snoring, The Village at Vanderbilt, Nashville, TN. Sponsored by Vanderbilt University Medical Center. Contact: Wendy Prostick, 615/322-6366.

MAY

2-4 — First Annual Postgraduate Clinical Forensic Medicine Conference, Brown Hotel, Louisville, KY. Contact: Write Clinical Forensic Medicine Conference, Dept of Emergency Medicine, University of Louisville, Louisville, KY 40292, or call 502/852-5689 or FAX 502/852-0066.

13-15 — Rheumatology and Allergy Update — 1994, Deer Creek State Park, Mt. Sterling, OH. Sponsored by the Center for Continuing Medical Education at the Ohio State University Medical Center. Contact: Sandi Latimer, University Medical Center Communications, 614/293-3660.

18-22 — Southeastern Orthopaedic Trauma Update, Opryland Hotel, Nashville, TN. Sponsored by Vanderbilt University Medical Center. Contact: Sherri Culp, 615/322-4030.

19-22 — 1994 Family Medicine/Primary Care Update, Vanderbilt University Medical Center, Nashville, TN. Sponsored by Vanderbilt University Medical Center. Contact: Kimberly Sammons, 615/322-4030.

26-28 — 19th Annual Sonography Symposium, Opryland Hotel, Nashville, TN. Sponsored by Vanderbilt University Medical Center. Contact: Sherri Culp, 615/322-4030.

JUNE

9-11 — 39th Great Smoky Mountains Pediatric Seminar, Park Vista Hotel, Gatlinburg, TN. Sponsored by The University of Tennessee Medical Center at Knoxville. Contact: Continuing Medical Education, 1924 Alcoa Highway, D-116, Knoxville, TN 37920; 615/544-9190.

23-25 — First Annual Meeting of the Southern Association for Family Practice, The Woodlands, Williamsburg, VA. Contact: Kathleen McLendon, Department of Education, 205/945-1840.

JULY

18-22 — Contemporary Clinical Neurology, Palmetto Dunes, Hilton Head, SC. Sponsored by Vanderbilt University Medical Center. Contact: Marilyn D'Asaro, 615/322-4030.

26-29 — Contemporary Medical Imaging XI, Hilton Head, SC. Sponsored by Vanderbilt University Medical Center. Contact: Sherri Culp, 615/322-4030.

28-30 — Seventh Annual Meeting of the Southern Association for Oncology, Jekyll Island Club Hotel, Jekyll Island, GA. Contact: Write to Linda Willingham, Coordinator, SAO, PO Box 190088, Birmingham, AL 35219-0088 or call 205/942-0530.

AUGUST

4-5 — Functional Endoscopic Sinus Surgery Workshop 1994, Vanderbilt University Medical Center, Nashville, TN. Contact: Sherri Culp, 615/322-4030.

19-21 — Southern Orthopaedic Association 1994 Annual Meeting, The Southampton Princess, Bermuda. Contact: Linda Willingham, 205/945-1848.

SEPTEMBER

24 — Eleventh Annual Ophthalmology Seminar: Uveitis Update. Audubon Regional Medical Center, Louisville, KY. Contact: Cathy Edens, 240 Audubon Medical Plaza, Louisville, KY 40217; 502/636-2823.

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10 mg TABLETS (loratadine)

* *In studies with CLARITIN Tablets at doses 2 to 4 times higher than the recommended dose of 10 mg, a dose-related increase in the incidence of somnolence was observed.*

† *Relief began in 13% of treated patients vs 4% of placebo-treated patients within 30 minutes (P=.04). At 2 hours, 48% of patients receiving placebo experienced relief. Distribution of onset times was significantly earlier for CLARITIN Tablets vs placebo (P=.03).*

Please see following page for brief summary of Prescribing Information.

CLARITIN®
brand of loratadine

TABLETS
Long-Acting Antihistamine

BRIEF SUMMARY
(For full Prescribing Information, see package insert.)

INDICATIONS AND USAGE
CLARITIN Tablets are indicated for the relief of nasal and non-nasal symptoms of seasonal allergic rhinitis.

CONTRAINDICATIONS
CLARITIN Tablets are contraindicated in patients who are hypersensitive to this medication or to any of its ingredients.

PRECAUTIONS
General: Patients with liver impairment should be given a lower initial dose (10 mg every other day) because they have reduced clearance of CLARITIN Tablets.

Drug Interactions: The coadministration of a single 20 mg dose of CLARITIN Tablets (double the recommended daily dose) and a 200 mg dose of ketoconazole twice daily to 12 subjects resulted in increased plasma concentrations of loratadine (180% increase in AUC) and its active metabolite, descarboethoxyloratadine (56% increase in AUC). However, no related changes were noted in the DTc on ECGs taken at 2, 6, and 24 hours after the coadministration of loratadine and ketoconazole. Also, there were no significant differences in clinical adverse events between CLARITIN Tablet groups with or without ketoconazole.

Other drugs known to inhibit hepatic metabolism should be coadministered with caution until definitive interaction studies can be completed. The number of subjects who concomitantly received macrolide antibiotics, cimetidine, ranitidine, or theophylline along with CLARITIN Tablets in controlled clinical trials is too small to rule out possible drug-drug interactions. There does not appear to be an increase in adverse events in subjects who received oral contraceptives and CLARITIN Tablets compared to placebo.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: In an 18-month oncogenicity study in mice and a 2-year study in rats, loratadine was administered in the diet at doses up to 40 mg/kg (mice) and 25 mg/kg (rats). In the carcinogenicity studies, pharmacokinetic assessments were carried out to determine animal exposure to the drug. AUC data demonstrated that the exposure of mice given 40 mg/kg of loratadine was 3.6 (loratadine) and 18 (active metabolite) times higher than a human given 10 mg/day. Exposure of rats given 25 mg/kg of loratadine was 28 (loratadine) and 67 (active metabolite) times higher than a human given 10 mg/day. Male mice given 40 mg/kg had a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) than concurrent controls. In rats, a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) was observed in males given 10 mg/kg and males and females given 25 mg/kg. The clinical significance of these findings during long-term use of CLARITIN Tablets is not known.

In mutagenicity studies, there was no evidence of mutagenic potential in reverse (AMES) or forward point mutation (CHO-HGPRT) assays, or in the assay for DNA damage (Rat Primary Hepatocyte Unscheduled DNA Assay) or in two assays for chromosomal aberrations (Human Peripheral Blood Lymphocyte Clastogenesis Assay and the Mouse Bone Marrow Erythrocyte Micronucleus Assay). In the Mouse Lymphoma Assay, a positive finding occurred in the nonactivated but not the activated phase of the study.

Loratadine administration produced hepatic microsomal enzyme induction in the mouse at 40 mg/kg and rat at 25 mg/kg, but not at lower doses.

Decreased fertility in male rats, shown by lower female conception rates, occurred at approximately 64 mg/kg and was reversible with cessation of dosing. Loratadine had no effect on male or female fertility or reproduction in the rat at doses of approximately 24 mg/kg.

Pregnancy Category B There was no evidence of animal teratogenicity in studies performed in rats and rabbits. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, CLARITIN Tablets should be used during pregnancy only if clearly needed.

Nursing Mothers: Loratadine and its metabolite, descarboethoxyloratadine, pass easily into breast milk and achieve concentrations that are equivalent to plasma levels with an AUC_{milk}/AUC_{plasma} ratio of 1.17 and 0.85 for the parent and active metabolite, respectively. Following a single oral dose of 40 mg, a small amount of loratadine and metabolite was excreted into the breast milk (approximately 0.03% of 40 mg over 48 hours). A decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Caution should be exercised when CLARITIN Tablets are administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children below the age of 12 years have not been established.

ADVERSE REACTIONS
Approximately 90,000 patients received CLARITIN Tablets 10 mg once daily in controlled and uncontrolled studies. Placebo-controlled clinical trials at the recommended dose of 10 mg once a day varied from 2 weeks to 6 months' duration. The rate of premature withdrawal from these trials was approximately 2% in both the treated and placebo groups.

REPORTED ADVERSE EVENTS WITH AN INCIDENCE OF MORE THAN 2% IN PLACEBO-CONTROLLED ALLERGIC RHINITIS CLINICAL TRIALS
PERCENT OF PATIENTS REPORTING

	LORATADINE 10 mg QD n = 1926	PLACEBO n = 2545	CLEMASTINE 1 mg BID n = 536	TERFENADINE 60 mg BID n = 684
Headache	12	11	8	8
Somnolence	8	6	22	9
Fatigue	4	3	10	2
Dry Mouth	3	2	4	3

Adverse event rates did not appear to differ significantly based on age, sex, or race, although the number of non-white subjects was relatively small.

In addition to those adverse events reported above, the following adverse events have been reported in 2% or fewer patients:

Autonomic Nervous System Altered salivation, increased sweating, altered lacrimation, hypoesthesia, impotence, thirst, flushing.
Body As A Whole Conjunctivitis, blurred vision, earache, eye pain, tinnitus, asthenia, weight gain, back pain, leg cramps, malaise, chest pain, rigors, fever, aggravated allergy, upper respiratory infection, angioneurotic edema.
Cardiovascular System Hypotension, hypertension, palpitations, syncope, tachycardia.
Central and Peripheral Nervous System Hyperkinesia, blepharospasm, paresthesia, dizziness, migraine, tremor, vertigo, dysphonia.
Gastrointestinal System Abdominal distress, nausea, vomiting, flatulence, gastritis, constipation, diarrhea, altered taste, increased appetite, anorexia, dyspepsia, stomatitis, toothache.
Musculoskeletal System Arthralgia, myalgia.
Psychiatric Anxiety, depression, agitation, insomnia, paroniria, amnesia, impaired concentration, confusion, decreased libido, nervousness.
Reproductive System Breast pain, menorrhagia, dysmenorrhea, vaginitis.
Respiratory System Nasal dryness, epistaxis, pharyngitis, dyspnea, nasal congestion, coughing, rhinitis, hemoptysis, sinusitis, sneezing, bronchospasm, bronchitis, laryngitis.
Skin and Appendages Dermatitis, dry hair, dry skin, urticaria, rash, pruritus, photosensitivity reaction, purpura.
Urinary System Urinary discoloration, altered micturition.

In addition, the following spontaneous adverse events have been reported rarely during the marketing of loratadine: peripheral edema, abnormal hepatic function, including jaundice, hepatitis, and hepatic necrosis, alopecia, seizures, breast enlargement, erythema multiforme, and anaphylaxis.

OVERDOSAGE
Somnolence, tachycardia, and headache have been reported with overdoses greater than 10 mg (40 to 180 mg). In the event of overdosage, general symptomatic and supportive measures should be instituted promptly and maintained for as long as necessary.

Treatment of overdosage would reasonably consist of emesis (ipecac syrup), except in patients with impaired consciousness, followed by the administration of activated charcoal to absorb any remaining drug. If vomiting is unsuccessful, or contraindicated, gastric lavage should be performed with normal saline. Saline cathartics may also be of value for rapid dilution of bowel contents. Loratadine is not eliminated by hemodialysis. It is not known if loratadine is eliminated by peritoneal dialysis.

Oral LD_{50} values for loratadine were greater than 5000 mg/kg in rats and mice. Doses as high as 10 times the recommended clinical doses showed no effects in rats, mice, and monkeys.

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Reference
1. Bédard P-M, Del Carpio J, Drouin MA, et al. Onset of action of loratadine and placebo and other efficacy variables in patients with seasonal allergic rhinitis. Clin Ther. 1992;14:268-275.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

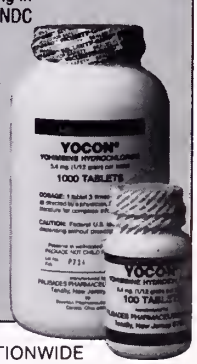
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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- **Once-a-day dosing**
- **Low incidence of adverse effects**

  In controlled clinical trials using the recommended dose, the incidence of headache (12%), somnolence (8%), fatigue (4%), and dry mouth (3%) with CLARITIN Tablets was similar to that of placebo (11%, 6%, 3%, and 2%, respectively).
- **Over 1 billion patient days of worldwide experience**

Clear Benefits From Start To Finish

Once-a-day

Claritin®

10 mg TABLETS (loratadine)

* *In studies with CLARITIN Tablets at doses 2 to 4 times higher than the recommended dose of 10 mg, a dose-related increase in the incidence of somnolence was observed.*

† *Relief began in 13% of treated patients vs 4% of placebo-treated patients within 30 minutes (P=.04). At 2 hours, 48% of patients receiving placebo experienced relief. Distribution of onset times was significantly earlier for CLARITIN Tablets vs placebo (P=.03).*

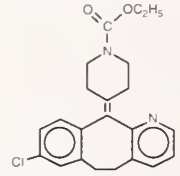
Please see following page for brief summary of Prescribing Information.

CLARITIN®
brand of loratadine
TABLETS
Long-Acting Antihistamine

PRODUCT INFORMATION

DESCRIPTION CLARITIN Tablets contain 10 mg micronized loratadine, an antihistamine, to be administered orally. They also contain the following inactive ingredients: corn starch, lactose, and magnesium stearate.

Loratadine is a white to off-white powder not soluble in water, but very soluble in acetone, alcohol, and chloroform. It has a molecular weight of 382.89, and empirical formula of $C_{22}H_{23}ClN_2O_2$; its chemical name is ethyl 4-(8-chloro-5,6-dihydro-11*H*-benzo[5,6]cyclohepta[1,2-*b*]pyridin-11-ylidene)-1-piperidinecarboxylate and has the following structural formula:



CLINICAL PHARMACOLOGY Loratadine is a long-acting tricyclic antihistamine with selective peripheral histamine H_1-receptor antagonistic activity.

Human histamine skin wheal studies following single and repeated 10 mg oral doses of CLARITIN Tablets have shown that the drug exhibits an antihistaminic effect beginning within 1 to 3 hours, reaching a maximum at 8 to 12 hours and lasting in excess of 24 hours. There was no evidence of tolerance to this effect after 28 days of dosing with CLARITIN Tablets.

Pharmacokinetic studies following single and multiple oral doses of loratadine in 115 volunteers showed that loratadine is rapidly absorbed and extensively metabolized to an active metabolite (descarboethoxyloratadine). The specific enzyme systems responsible for metabolism have not been identified. Approximately 80% of the total dose administered can be found equally distributed between urine and feces in the form of metabolic products after 10 days. The mean elimination half-lives found in studies in normal adult subjects (n = 54) were 8.4 hours (range = 3 to 20 hours) for loratadine and 28 hours (range = 8.8 to 92 hours) for the major active metabolite (descarboethoxyloratadine). In nearly all patients, exposure (AUC) to the metabolite is greater than exposure to parent loratadine.

In a study involving twelve healthy geriatric subjects (66 to 78 years old), the AUC and peak plasma levels (Cmax) of both loratadine and descarboethoxyloratadine were significantly higher (approximately 50% increased) than in studies of younger subjects. The mean elimination half-lives for the elderly subjects were 18.2 hours (range = 6.7 to 37 hours) for loratadine and 17.5 hours (range = 11 to 38 hours) for the active metabolite.

Loratadine, dosed once daily, had reached steady-state by the fifth daily dose. The pharmacokinetics of loratadine and descarboethoxyloratadine are dose independent over the dose range of 10 to 40 mg and are not significantly altered by the duration of treatment.

In the clinical efficacy studies, CLARITIN Tablets were administered before meals. In a single-dose study, food increased the AUC of loratadine by approximately 40% and of descarboethoxyloratadine by approximately 15%. The time to peak plasma concentration (Tmax) of loratadine and descarboethoxyloratadine was delayed by 1 hour with a meal. Although these differences would not be expected to be clinically important, CLARITIN Tablets should be administered on an empty stomach.

In patients with chronic renal impairment (Creatinine Clearance ≤ 30 mL/min) both the AUC and peak plasma levels (Cmax) increased on average by approximately 73% for loratadine; and approximately by 120% for descarboethoxyloratadine, compared to individuals with normal renal function. The mean elimination half-lives of loratadine (7.6 hours) and descarboethoxyloratadine (23.9 hours) were not significantly different from that observed in normal subjects. Hemodialysis does not have an effect on the pharmacokinetics of loratadine or its active metabolite (descarboethoxyloratadine) in subjects with chronic renal impairment.

In patients with chronic alcoholic liver disease the AUC and peak plasma levels (Cmax) of loratadine were double while the pharmacokinetic profile of the active metabolite (descarboethoxyloratadine) was not significantly changed from that in normals. The elimination half-lives for loratadine and descarboethoxyloratadine were 24 hours and 37 hours, respectively, and increased with increasing severity of liver disease.

There was considerable variability in the pharmacokinetic data in all studies of CLARITIN Tablets, probably due to the extensive first-pass metabolism. Individual histograms of area under the curve, clearance, and volume of distribution showed a log normal distribution with a 25-fold range in distribution in healthy subjects.

Loratadine is about 97% bound to plasma proteins at the expected concentrations (2.5 to 100 ng/mL) after a therapeutic dose. Loratadine does not affect the plasma protein binding of warfarin and digoxin. The metabolite descarboethoxyloratadine is 73% to 77% bound to plasma proteins (at 0.5 to 100 ng/mL).

Whole body autoradiographic studies in rats and monkeys, radiolabeled tissue distribution studies in mice and rats, and *in vivo* radioligand studies in mice have shown that neither loratadine nor its metabolites readily cross the blood-brain barrier. Radioligand binding studies with guinea pig pulmonary and brain H_1-receptors indicate that there was preferential binding to peripheral versus central nervous system H_1-receptors.

Clinical trials of CLARITIN Tablets involved over 10,700 patients who received either CLARITIN Tablets or another antihistamine and/or placebo in double-blind randomized controlled studies. In placebo-controlled trials, 10 mg once daily of CLARITIN Tablets was superior to placebo and similar to clemastine (1 mg BID) or terfenadine (60 mg BID) in effects on nasal and non-nasal symptoms of allergic rhinitis. In these studies, somnolence occurred less frequently with CLARITIN Tablets than with clemastine and at about the same frequency as terfenadine or placebo. In studies with CLARITIN Tablets at doses 2 to 4 times higher than the recommended dose of 10 mg, a dose-related increase in the incidence of somnolence was observed. Therefore, some patients, particularly those with hepatic or renal impairment and the elderly, may experience somnolence.

In a study in which CLARITIN Tablets were administered at 4 times the clinical dose for 90 days, no clinically significant increase in the QTc was seen on ECGs.

INDICATIONS AND USAGE CLARITIN Tablets are indicated for the relief of nasal and non-nasal symptoms of seasonal allergic rhinitis.

CONTRAINDICATIONS CLARITIN Tablets are contraindicated in patients who are hypersensitive to this medication or to any of its ingredients.

PRECAUTIONS **General:** Patients with liver impairment should be given a lower initial dose (10 mg every other day) because they have reduced clearance of CLARITIN Tablets.

Drug Interactions: The coadministration of a single 20 mg dose of CLARITIN Tablets (double the recommended daily dose) and a 200 mg dose of ketoconazole twice daily to 12 subjects resulted in increased plasma concentrations of loratadine (180% increase in AUC) and its active metabolite, descarboethoxyloratadine (56% increase in AUC). However, no related changes were noted in the QTc on ECGs taken at 2, 6, and 24 hours after the coadministration of loratadine and ketoconazole. Also, there were no significant differences in clinical adverse events between CLARITIN Tablet groups with or without ketoconazole.

Other drugs known to inhibit hepatic metabolism should be coadministered with caution until definitive interaction studies can be completed. The number of subjects who concomitantly received macrolide antibiotics, cimetidine, ranitidine, or theophylline along with CLARITIN Tablets in controlled clinical trials is too small to rule out possible drug-drug interactions. There does not appear to be an increase in adverse events in subjects who received oral contraceptives and CLARITIN Tablets compared to placebo.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: In an 18-month oncogenicity study in mice and a 2-year study in rats, loratadine was administered in the diet at doses up to 40 mg/kg (mice) and 25 mg/kg (rats). In the carcinogenicity studies, pharmacokinetic assessments were carried out to determine animal exposure to the drug. AUC data demonstrated that the exposure of mice given 40 mg/kg of loratadine was 3.6 (loratadine) and 18 (active metabolite) times higher than a human given 10 mg/day. Exposure of rats given 25 mg/kg of loratadine was 28 (loratadine) and 67 (active metabolite) times higher than a human given 10 mg/day. Male mice given 40 mg/kg had a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) than concurrent controls. In rats, a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) was observed in males given 10 mg/kg and males and females given 25 mg/kg. The clinical significance of these findings during long-term use of CLARITIN Tablets is not known.

In mutagenicity studies, there was no evidence of mutagenic potential in reverse (AMES) or forward point mutation (CHO-HGPRT) assays, or in the assay for DNA damage (Rat Primary Hepatocyte Unscheduled DNA Assay) or in two assays for chromosomal aberrations (Human Peripheral Blood Lymphocyte Clastogenesis Assay and the Mouse Bone Marrow Erythrocyte Micronucleus Assay). In the Mouse Lymphoma Assay, a positive finding occurred in the nonactivated but not the activated phase of the study.

Loratadine administration produced hepatic microsomal enzyme induction in the mouse at 40 mg/kg and rat at 25 mg/kg, but not at lower doses.

Decreased fertility in male rats, shown by lower female conception rates, occurred at approximately 64 mg/kg and was reversible with cessation of dosing. Loratadine had no effect on male or female fertility or reproduction in the rat at doses of approximately 24 mg/kg.

Pregnancy Category B: There was no evidence of animal teratogenicity in studies performed in rats and rabbits. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, CLARITIN Tablets should be used during pregnancy only if clearly needed.

Nursing Mothers: Loratadine and its metabolite, descarboethoxyloratadine, pass easily into breast milk and achieve concentrations that are equivalent to plasma levels with an AUC_{milk}/AUC_{plasma} ratio of 1.17 and 0.85 for the parent and active metabolite, respectively. Following a single oral dose of 40 mg, a small amount of loratadine and metabolite was excreted into the breast milk (approximately 0.03% of 40 mg over 48 hours). A decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Caution should be exercised when CLARITIN Tablets are administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children below the age of 12 years have not been established.

ADVERSE REACTIONS Approximately 90,000 patients received CLARITIN Tablets 10 mg once daily in controlled and uncontrolled studies. Placebo-controlled clinical trials at the recommended dose of 10 mg once a day varied from 2 weeks' to 6 months' duration. The rate of premature withdrawal from these trials was approximately 2% in both the treated and placebo groups.

REPORTED ADVERSE EVENTS WITH AN INCIDENCE OF MORE THAN 2% IN PLACEBO-CONTROLLED ALLERGIC RHINITIS CLINICAL TRIALS

PERCENT OF PATIENTS REPORTING

	LORATADINE 10 mg OD n = 1926	PLACEBO n = 2545	CLEMASTINE 1 mg BID n = 536	TERFENADINE 60 mg BID n = 684
Headache	12	11	8	8
Somnolence	8	6	22	9
Fatigue	4	3	10	2
Dry Mouth	3	2	4	3

Adverse event rates did not appear to differ significantly based on age or race, although the number of non-white subjects was relatively sma

In addition to those adverse events reported above, the following adv events have been reported in 2% or fewer patients.

Autonomic Nervous System Altered salivation, increased swea altered lacrimation, hypoesthesia, impotence, thirst, flushing.

Body As A Whole Conjunctivitis, blurred vision, earache, eye tinnitus, asthenia, weight gain, back pain, leg cramps, malaise, chest rigors, fever, aggravated allergy, upper respiratory infection, angioneu edema.

Cardiovascular System Hypotension, hypertension, palpitations, cope, tachycardia.

Central and Peripheral Nervous System Hyperkinesia, blepharospa paresthesia, dizziness, migraine, tremor, vertigo, dysphonia.

Gastrointestinal System Abdominal distress, nausea, vomiting, f lence, gastritis, constipation, diarrhea, altered taste, increased appe anorexia, dyspepsia, stomatitis, toothache.

Musculoskeletal System Arthralgia, myalgia.

Psychiatric Anxiety, depression, agitation, insomnia, paroniria, amn impaired concentration, confusion, decreased libido, nervousness.

Reproductive System Breast pain, menorrhagia, dysmenorrhea, vagi

Respiratory System Nasal dryness, epistaxis, pharyngitis, dysp nasal congestion, coughing, rhinitis, hemoptysis, sinusitis, sneezing, b chospasm, bronchitis, laryngitis.

Skin and Appendages Dermatitis, dry hair, dry skin, urticaria, rash, ritus, photosensitivity reaction, purpura.

Urinary System Urinary discoloration, altered micturition.

In addition, the following spontaneous adverse events have been repo rarely during the marketing of loratadine: peripheral edema; abnorma patic function, including jaundice, hepatitis, and hepatic necrosis; alop seizures; breast enlargement; erythema multiforme; and anaphylaxis.

DRUG ABUSE AND DEPENDENCE There is no information to indicate abuse or dependency occurs with CLARITIN Tablets.

OVERDOSAGE Somnolence, tachycardia, and headache have been ported with overdoses greater than 10 mg (40 to 180 mg). In the ever overdosage, general symptomatic and supportive measures shoul instituted promptly and maintained for as long as necessary.

Treatment of overdosage would reasonably consist of emesis (ipe syrup), except in patients with impaired consciousness, followed by the ministration of activated charcoal to absorb any remaining drug. If vomi is unsuccessful, or contraindicated, gastric lavage should be perfor with normal saline. Saline cathartics may also be of value for rapid dilu of bowel contents. Loratadine is not eliminated by hemodialysis. It is known if loratadine is eliminated by peritoneal dialysis.

Oral LD_{50} values for loratadine were greater than 5000 mg/kg in rats mice. Doses as high as 10 times the recommended clinical doses sho no effects in rats, mice, and monkeys.

DOSAGE AND ADMINISTRATION Adults and children 12 years of age over: One 10 mg tablet daily on an empty stomach.

In patients with liver failure, 10 mg every other day should be the st ing dose.

HOW SUPPLIED CLARITIN Tablets, 10 mg, white to off-white compres tablets; impressed with the product identification number "458" on side; and "CLARITIN 10" on the other; high density polyethylene plastic b ties of 100 (NDC 0085-0458-03). Also available, CLARITIN Unit-of-Use p ages of 14 tablets (7 tablets per blister card) (NDC 0085-0458-01) and tablets (10 tablets per blister card) (NDC 0085-0458-05); and 10 x 10 ta Unit Dose-Hospital Pack (NDC 0085-0458-04).

Protect Unit-of-Use packaging and Unit Dose-Hospital Pack fr excessive moisture. Store between 2° and 30°C (36° and 86°F).

Schering®

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Kenilworth, NJ 07033 USA

Rev. 9/93

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JOURNAL OF THE
KENTUCKY MEDICAL
ASSOCIATION

VOLUME 92, NUMBER 5 MAY 1994

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***COVER:** A Louisville surgeon discusses the pros ond cons of breast-conserving surgery. See article on page 176. Cover art illustrates a patient being informed about breast-conserving surgery as an option to treat her breast cancer. With permission to reprint from Michael J. Edwards, MD. Illustration and design by Lee Wade of Louisville.*

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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Second-class postage paid at Louisville, KY and additional offices. Yearly subscription rates: $25 domestic; $30 foreign. Single issues $3 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association*, 301 N Hurstbourne Pkwy, Suite 200, Louisville, KY 40222-8512. EDITORIAL AND ADVERTISING: Telephone 502/426-6200.

Listed in Index Medicus. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

National advertising representative: State Medical Journal Advertising Bureau, Inc, 11437 W 106th St, Overland Park, KS 66214, phone 800/788-2360.

The *Journal*, its editors, and the Kentucky Medical Association do not assume responsibility for the opinions and statements of its contributors and advertisers. The *Journal* reserves the right to make the final decision on all content and advertisements.

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Printed by the Ovid Bell Press, Inc, Fulton, Missouri 65251.

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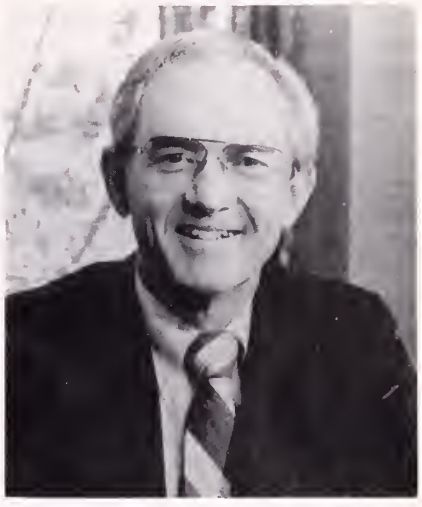
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Managing Managed Care



Robert R. Goodin, MD

The term managed care, HMOs, PPOs, and capitation have long been anathema to physicians. We spent long arduous years of study and work in order to be the decision makers in patient care and now find ourselves less and less in control. In 1940 when Henry Kaiser hired Dr Sidney Garfield with a prepaid contract to provide care to workers building the Hoover Dam, little did anyone expect the subsequent development in managed health care. President Nixon invented and embraced the term HMO in 1973 and blessed it with federal subsidy. By 1980 the rapid rise in health care costs had catalyzed corporate interest and in fact demands for cost containment through change in practice patterns and shifting of the risks to providers in health care. This further accelerated the move nationwide to managed care systems.

"We must assure that this means physicians managing health care and not physicians being managed."

There are, of course, many good reasons for the high cost of health care (increased life expectancy, new technology, medical liability costs, horrible American lifestyles), but we must accept that there is evidence that managed care systems can help control rising health care costs. We must assure that this means physicians managing health care and not physicians being managed.

Over the past 3 to 5 years, the spread of managed care has become an epidemic and along with it a near panic state among physicians worried about what to do, not only to protect quality patient care but literally to protect their practices. It is very important that we physicians realize completely that the rapid move to managed care started before and will continue regardless of health system reform at the state and national levels. In 1980 only 5% to 7% of people were enrolled in HMOs, while today 35% of Americans belong to either HMOs or PPOs. Today, 95% of insured employees belong to managed care plans. Only 6% to 10% of Medicare and Medicaid patients (US total 60 million) belong to managed care systems, but we can expect this to change dramatically in the near future. In fact many experts predict that by the year 2000 less than 5% of health care will be delivered by fee for service while 50% to 75% will be through capitated plans.

In September 1993 your House of Delegates directed the Board of Trustees to establish a feasibility study committee to determine if KMA should develop an economic entity that would preserve KMA members' access to and decision making ability in various managed care systems that may evolve. Your committee is pursuing its assigned task.

"In September 1993 your House of Delegates directed the Board of Trustees to establish a feasibility study committee to determine if KMA should develop an economic entity that would preserve KMA members' access to and decision making ability in various managed care systems that may evolve. Your committee is pursuing its assigned task."

Many states have already established or are in the process of establishing such entities. These vary from full HMO-IPA models (CT, SD, OK, and FL) to PPOs (NY, SC, and MS) to MSOs (MI, IL). In Kentucky we already have physician organizations, physician alliances, PPOs, hospitals

"At this point, I would urge that physicians not panic and be very careful before signing on to any alliances."

buying medical practices, and early work toward physician/hospital organizations.

Mr William Applegate (KMA) and I had the opportunity to interact with many of these states both in December 1993 and in February 1994. A special called meeting of your KMA Board of Trustees was held on March 3, 1994, specifically to spend a full day discussing options that may fulfill Kentucky physicians' needs. The importance of these decisions to Kentucky physicians fully justifies the time and expense required of our board and committee.

As a minimum, we must develop within KMA the ability to provide current and accurate information to our physicians, either in-house or through a network of physician friendly consultants. This information must include HMOs, IPAs, PPOs, EPOs, MSOs, POs, and PHOs. Additionally, we physicians will need advice regarding outcomes research, total quality management, practice parameters, physician practice mergers, credentialing, utilization review, and physician profiling. We obviously want physicians guiding physicians and must not allow others to do these tasks for us. With the diversity among us — rural and urban, primary care specialists and other specialists — our needs are diverse, but the KMA must accept the challenge to provide this leadership role, and I have no doubt that we can.

Consistent messages coming from our various discussions and input include:

- The option to do nothing does not exist.
- Managed care in various forms will be the standard delivery system of the future.
- Physicians must be willing to make changes in practice patterns but at the same time not compromise quality patient care.
- Alliances of many varieties will develop in the public sector as well as between hospitals, insurance companies, HMOs, and physicians.
- Physician practice mergers will accelerate and solo practice will become obsolete.
- Physicians must become well informed regarding all aspects of managed care.

At this point, I would urge that physicians not panic and be very careful before signing on to any alliances. Physicians must first form their own physician organization and then enter relationships well informed and insisting on equal governance and decision-making power. We have an obligation, in fact, to protect our patients from decisions made by non-

"We obviously want physicians guiding physicians and must not allow others to do these tasks for us."

physicians that may well jeopardize patient care and patient choice. Regardless of the difficulties that lie ahead, physicians must remain united and not allow the divide and conquer strategies to disable the greatest profession in the world. So far, only physicians can practice medicine, and I am confident that with careful planning we can find amid this turbulent time of change some great opportunities to better serve our patients.

Robert R. Goodin, MD
KMA President-Elect

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Breast Conserving Surgery for Early Cancer: Who, When, Where, and How?

Michael J. Edwards, MD



Breast-conserving surgery combined with postoperative radiation therapy is a therapeutic option for the early stages of breast cancer that has been proven efficacious by multiple studies with long-term follow-up. The validity of this approach has been recently questioned following the discovery of erroneous data submitted by a single investigator to a study of the National Surgical Adjuvant Breast and Bowel Project. When this individual's contributed data was eliminated, and the residual data reexamined and reviewed by National Cancer Institute statisticians, the conclusions of the study were unchanged and supported other clinical investigations in affirming that breast-conserving therapy is an effective and appropriate treatment for early breast cancer. Marked geographical, institutional, and individual physician variation persists today regarding the acceptance of breast-conserving surgery in the treatment of breast carcinoma. Currently, the trend, however, is toward increased acceptance and utilization of this treatment option. A woman's choice of treatment can be remarkably enhanced if she is carefully provided the pros and cons of all treatment options and then allowed to choose.

More than one in 10 women in the United States will develop breast carcinoma. The American Cancer Society estimates that over 180,000 women will be diagnosed with breast cancer in 1994 and more than 46,000 will die of the disease. The medical community and general public have now recognized that breast cancer has reached truly epidemic proportions. This epidemic has prompted a more knowledgeable patient population, a broad acceptance of breast cancer screening, and a recent increase in funding for breast cancer research due to intense lobbying efforts by activists for women's issues.[1]

With the current widespread use of mammography and physical examination, more clinically favorable breast cancers are now being detected. The data regarding treatment of these early cancers are clear. A variety of surgical options are indicated depending on the particular histopathological subtype and the stage of the cancer (Table 1). However, three primary surgical options are currently most often required for the treatment of the early stages of invasive breast cancer. These include:

1. Total mastectomy (modified radical mastectomy) alone;
2. Breast-conserving surgery (partial mastectomy or so-called "lumpectomy") with postoperative radiation therapy; and
3. Total mastectomy followed by breast reconstruction at the time of mastectomy or at a later time.

All three options have equivalent therapeutic efficacy. In addition, all require surgical removal of at least levels I and II axillary lymph nodes for adequate staging. (A complete axillary lymphadenectomy is indicated for those patients with clinically identified positive nodes [see Table 1].) Total mastectomy alone is the simplest option but results in the greatest cosmetic defect. For superior cosmetic results, another option is breast-conserving surgery with postoperative radiation therapy. The disadvantage of this option is that it requires therapy over several weeks, and the residual breast parenchyma must be followed for local recurrence and the development of second primary carcinomas, just like the contralateral breast. Breast reconstruction after total mastectomy has the advantage of total breast removal,

From the Division of Surgical Oncology, Department of Surgery, University of Louisville School of Medicine, Louisville, KY.

Supported by NIH Grant CA 57527-02, Louisville, KY.

Reprint requests to Department of Surgery, Editorial Office, University of Louisville, Louisville, KY 40292 (Dr Edwards). Phone 502/852-7827.

Table 1. Variaus Stages and Histalagical Subtypes af Breast Cancers and Passible Treatment Optians

Stage/Histalagical Subtype	Treatment aptians
$T_1N_0M_0$ tubular carcinama	Partial mastectamy alane
Intraductal carcinama	Partial mastectamy and pastaperative radiatian therapy
$T_2N_0M_0$ Infiltrating ductal carcinama	Partial mastectamy, level I-II axillary lymphadenectamy, and pastaperative radiatian therapy
$T_2N_1M_0$ Infiltrating ductal carcinama	Partial mastectamy, camplete axillary lymphadenectamy, and pastaperative radiatian therapy
Intraductal carcinama	Tatal mastectamy alane
Intraductal carcinama	Tatal mastectamy and recanstructian (immediate ar delayed)
$T_2N_0M_0$ Infiltrating ductal carcinama	Tatal mastectamy and level I-II axillary lymphadenectamy
$T_2N_0M_0$ Infiltrating ductal carcinama	Tatal mastectamy, level I-II axillary lymphadenectamy, and recanstructian
$T_2N_1M_0$ Infiltrating ductal carcinama	Tatal mastectamy and camplete axillary lymphadenectamy
$pT_4N_0M_0$ Infiltrating ductal carcinama	Tatal mastectamy, level I-II axillary lymphadenectamy, and pastaperative radiatian therapy
$T_4N_0M_0$ Infiltrating ductal carcinama	Preoperative chematherapy, tatal mastectamy and camplete axillary lymphadenectamy, campletian chematherapy, and pastaperative radiatian therapy

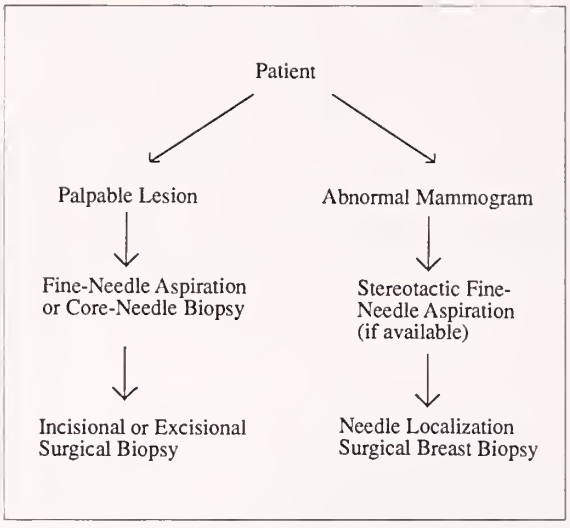


Fig 1 — Algorithm for the diagnosis of breast cancer.

but it requires a significantly more involved initial operation, and at least one additional operation for remodeling and nipple reconstruction. This review discusses the reasons and criteria for choosing the option of breast-conserving surgery.

Modern Breast Cancer Therapy

Twenty-five years ago, virtually all women with breast cancer presented with a palpable mass, had a breast biopsy with frozen section pathological examination while under general anesthesia, and underwent an immediate mastectomy. The patient learned of the cancer diagnosis and the subsequent mastectomy after awakening in the recovery room. Since then, the approach to breast cancer treatment has dramatically improved. More breast cancers are now detected by mammography than by physical examination. These small mammographically detected carcinomas are currently diagnosed by needle localization surgical breast biopsies. This approach, however, is quickly being supplanted by less invasive stereotactic needle breast biopsies. In addition, fine-needle aspiration for cytological analysis or core-needle biopsies for histological evaluation have replaced excisional and incisional surgical biopsies as the initial diagnostic procedure for the overwhelming majority of patients with palpable lesions (Fig 1).

Once the diagnosis of breast cancer is obtained, the patient is educated about the various treatment options. Several prospective randomized studies compared breast-conserving surgery and total mastectomy as treatment options for early breast cancer.[2,3,4,5] These studies have consistently reached the same conclusions. Patients treated by either breast-conserving surgery alone, breast-conserving surgery with postoperative radiation therapy, or by modified radical mastectomy have equivalent survival with long-term follow-up. However, patients treated by breast-conserving surgery alone have an increased incidence of local recurrence compared with patients treated by breast-conserving surgery and radiation therapy. Therefore, the current standard recommendation, to minimize the risk of local recurrence, is for patients to be treated by either total mastectomy or breast-conserving surgery with postoperative radiation therapy. This well established concept has been recently questioned after an Associated Press release reported the discovery of falsified data from a single investigator to a study of the National Surgical Adjuvant Breast and Bowel Project. Revised peer-reviewed analysis of the corrected data is currently pending. However, after excluding the entire data contributed from the individual in question, reexamination and review by statisticians of the National Cancer Institute concluded that the residual data supports multiple other studies in affirming that breast-conserving surgery with postoperative radiation therapy is an equivalent and effective option for the treatment of breast cancer.

The subset of patients most suitable for treat-

Table 2. Factors to Consider in Choice of Local Therapy

Important
• Tumor histopathology (biological behavior)
• Ability to achieve tumor margin with local excision
• Breast size
• Tumor location
• Staging
— Axillary nodal status
— "T" stage of primary
• Psychosocial factors
— Fear of recurrence
— Fear of radiation therapy
— Fear of surgery
— Concern over appearance
• Logistical problems
— Time off work
— Travel time (expense of travel)
— Ability to lie in position for radiation therapy
Less important
• Age
• Family history

ment by breast-conserving surgery alone is an area of ongoing research. Factors important in selecting patients for breast conservation and radiation therapy are outlined in Table 2.

Tumor Margin. Distinction between a "breast biopsy" performed with only diagnostic intent and a partial mastectomy or "lumpectomy" performed with therapeutic intent is essential. The therapeutic tumor excision should achieve a 1.0 cm margin, whenever possible. Also, the operative note and resulting pathology report should support the performance of a therapeutic tumor excision with histological negative margins. This clearly stated goal in the medical record is vitally important for future consultants who must determine whether the patient has had an adequate tumor excision. If either report is questionable or inconclusive, reexcision of the biopsy site is necessary. The M.D. Anderson Cancer Center (Houston, TX) follows this policy and reported that 50% of its patients who underwent reexcision of the biopsy site had residual tumor.[6] It is clear that one cannot solely rely on the final pathology report and achieve adequate local disease control; the surgical excision must be done with therapeutic intent.

The incision should be placed directly over the palpable breast abnormality (Fig 2). Skin removal is not necessary unless a previous biopsy has been performed, in which case the scar should be excised. A crucial step in achieving good cosmesis is to avoid thin skin flaps. Thick flaps preserve breast contour.

The goal of the partial mastectomy or "lumpectomy" is to remove the tumor and a small (approximately 1 cm) margin of normal breast tissue in all directions (Fig 3). Deep tumors should be approached by cutting through the breast tissue to a point just superior to the tumor to begin the excision. Excision of the pectoral fascia is not necessary unless the tumor impinges the fascia. All specimens should be appropriately inked and jointly processed by the surgeon and pathologist to ensure adequate margins.[7] Permanent pathological sections also aid the intraoperative assessment in determining adequacy of resection.

Drains should not be placed in the lumpectomy cavity, since allowing this space to fill with fibrin will help maintain breast contour. Attempts to reapproximate the breast tissue and obliterate the cavity should be avoided, since they frequently result in distortion of the breast contour.

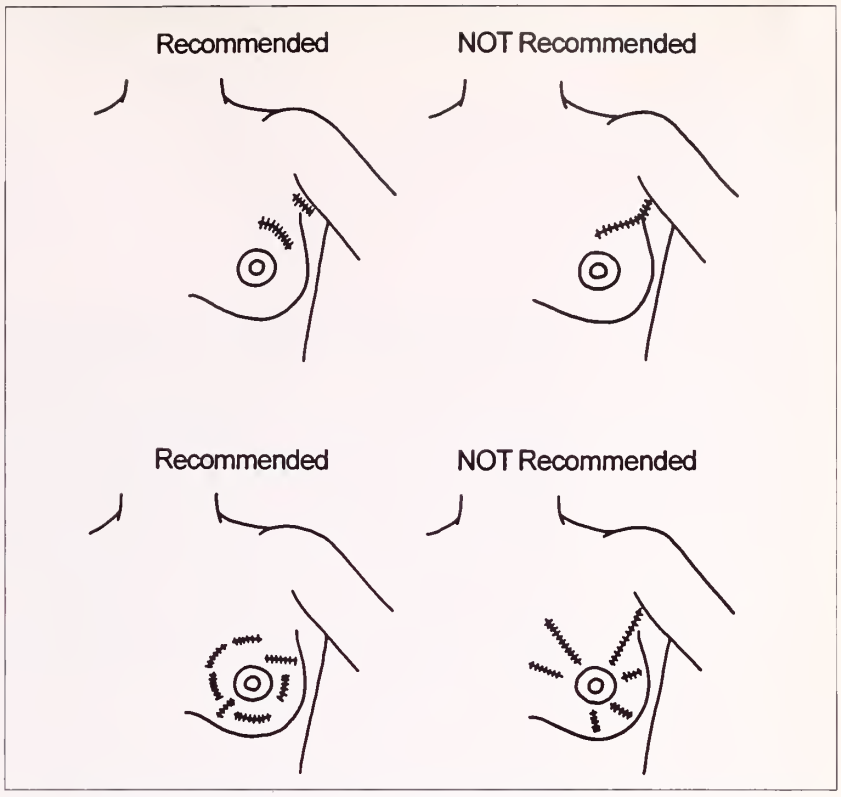


Fig 2 — Incisions for breast-conserving surgery. Radial incisions are useful only in the most medial inferior breast and at the axillary tail of Spence. Extension of the breast incision into the axilla is not recommended since contraction of such scars results in lateral and superior nipple retraction. The use of two separate incisions prevents this retraction. With permission from Margolese R, Poisson R, Shibata H, Pilch Y, Lerner H, Fisher B. The technique of segmental mastectomy (lumpectomy) and axillary dissection: a syllabus from the National Adjuvant Breast Project workshop. Surgery 1987;102:828-834.

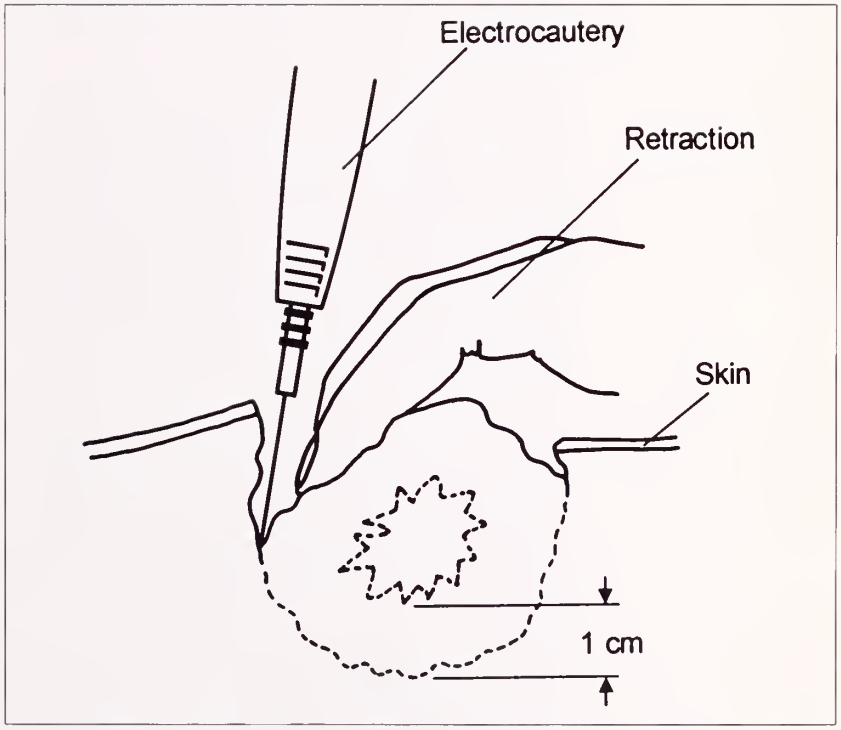


Fig 3 — Therapeutic breast cancer excision. Palpation is used to determine margin and site of breast parenchymal transection. With permission from Margolese R, Poisson R, Shibata H, Pilch Y, Lerner H, Fisher B. The technique of segmental mastectomy (lumpectomy) and axillary dissection: a syllabus from the National Adjuvant Breast Project workshop. Surgery 1987;102:828-834.

Skin closure with intradermal sutures avoids crosshatching.

Size of Breast. The breast should be of adequate size to allow for surgical excision of the tumor with histologically negative margins and still provide an adequate and acceptable cosmetic result. A solitary lesion that is less than 4 cm in diameter is preferable for the average-size breast. Tumor size must, however, be considered in the context of the overall size of the breast. In other words, larger breast cancers may be removed from women with larger breasts and still achieve an acceptable cosmetic result.

Tumor Site. Lesions that are centrally located in the subareolar breast may require removal of the nipple to achieve histologically negative margins. The primary reason for superior cosmetic results with breast-conserving surgery over total mastectomy and reconstruction is the ability to preserve the nipple areolar complex. If the nipple areolar complex must be sacrificed because of the central location of the tumor, this advantage is lost. Thus, most women with centrally located tumors are best treated with total mastectomy and reconstruction.

Axillary Nodal Status. Physical examination of the axilla should indicate the absence of suspicious lymph nodes or contain small mobile lymph nodes. Patients with clearly fixed or matted axillary lymph nodes have a markedly increased incidence of local recurrence and should undergo induction chemotherapy and then be reassessed for breast-conserving surgery and postoperative radiation therapy only if significant tumor response is achieved.

Advanced Primary Breast Carcinomas. Inflammatory carcinomas and locally advanced primary breast cancers have a very high rate of local recurrence with breast-conserving surgery and postoperative radiation therapy. Skin involvement, ulceration, chest wall fixation, muscle invasion, and dermal lymphatic invasion preclude breast conservation.

Psychosocial and Logistical Problems. Patients selected for breast-conserving surgery and postoperative radiation therapy must be committed to the treatment plan. The therapy required to preserve the breast is more intense than that of total mastectomy. All patients must undergo daily outpatient radiation therapy for 5 to 6 weeks. The additional time required for treatment, coupled with the limited access to radiation facilities for rural populations, are important considerations for many women. Following the completion of radiation therapy, all patients must be compliant with follow-up examinations to detect local regional recurrence, which is frequently curable by excision.

Age and Family History. The age of the patient and a significant family history of breast cancer are less important factors, which alone do not preclude breast-conserving surgery. Although younger women are more likely to prefer breast-conserving surgery, no patient is too old. In addition, a strong family history for breast cancer is not a contraindication for breast conservation. Such patients should be counseled regarding individual risk for subsequent ipsilateral as well as contralateral breast carcinomas.

Other Contraindications. Collagen vascular diseases such as systemic lupus erythematosus and scleroderma have been reported to have exaggerated responses to radiation therapy and should not be treated by breast-conserving surgery and radiation therapy.[8] First and second trimester pregnancy, prior radiation therapy of the breast area, and patients with multiple primary tumors are not candidates for breast conservation. In addition, patients with diffuse microcalcifications on mammography or multicentric ductal carcinoma in situ are best treated by total mastectomy.

Current Practice

Breast-conserving surgery combined with postoperative radiation therapy has been extensively studied and has become a well-established treatment for early stages of breast carcinoma. The status of this option was summarized by the National Institute of Health's Consensus Development Conference Statement of 1990:

> "Breast conservation treatment is an appropriate method of primary therapy for the majority of women with Stage I and II breast cancer and is preferable because it provides survival equivalent to total mastectomy and axillary dissection while preserving the breast."

Despite the recommendation of the National Institute of Health, the extent to which breast-conserving surgery has been adopted has varied remarkably according to geography, institution, and the individual physician.[9] A recent study us-

ing national data from Medicare claims for inpatient care provided in 1986, and analyzed according to the patient's state of residence, found a range of breast-conserving surgery performed, from a low of 3.5% for patients in Kentucky to a high of greater than 20% in certain Middle Atlantic States and New England.[10] Breast-conserving surgery was used more often in urban areas than in rural areas, in teaching hospitals than in nonteaching hospitals, and in hospitals with on-site radiation treatment or geriatric services than in those without such services. A remarkable variation persists today in many areas, but the trend in most is toward an increase in breast conservation. For example, in 1989, only 30% of operable breast cancers at Roswell Park Cancer Institute (Buffalo, NY) were treated by breast-conserving surgery, but this increased to more than 60% by January 1994.[11]

Several factors are commonly put forth by those who consistently choose total mastectomy over breast conservation. In the past, poor cosmetic results with breast-conserving surgery were attributed to radiation therapy and cited as a primary reason for preferring total mastectomy. We know now that proper patient selection, and more importantly, the proper surgical technique of the breast-conserving operation, and not radiation therapy, are the major determinants for optimal posttreatment breast appearance.[12] Also, an increased number of advanced cancers is frequently cited for choosing total mastectomy over breast conservation. Combined data from the 1991-1992 reports of the Kentucky Cancer Registry show an increased incidence of advanced stages of breast cancer in areas around Louisville, Lexington, and eastern Kentucky. The magnitude of this difference is small, however, to totally explain the current preference for total mastectomy. Limited access to major centers appears to be a significant factor. Rural states such as Kentucky have large numbers of patients with limited resources and relatively limited access to radiation treatment facilities.

Physician and patient bias appear, however, to also be important factors. Some women have a strong bias in favor of total mastectomy. In fact, it is not uncommon that the diagnosis of cancer in one breast will prompt some women to request bilateral mastectomies to avoid the future development of contralateral breast cancer. The best approach for dealing with this anxiety and bias is patient education with appropriate consultation. If early breast cancer can be adequately treated by breast-conserving surgery and postoperative radiation therapy, the patient should be informed by both the surgeon and radiation therapist that the more conservative approach is associated with the same long-term survival as with total mastectomy. If the patient understands this after a balanced presentation of the options and still prefers a total mastectomy, then she should undergo total mastectomy to prevent the patient's concern over the possibility of local recurrence.

Primary physicians and surgeons should carefully convey to their patients the safety of breast-conserving surgery. Exact wording is important. Phrases such as, "The operations *seem* to be equal," or "It *appears* that breast conservation is an equal treatment," induce a certain level of doubt as to its effectiveness. If patients are told: "I have good news. Your tumor is small and can be effectively treated with a combination of surgery and radiation therapy, which will allow you to keep your breast. Your breast does not have to be removed unless that is your preferred choice," then the patient is much more likely to choose the breast-conserving option.

Because therapeutic options yield equivalent survival outcomes, women have "a right to choose" when it comes to treatment for early stages of breast carcinoma. The choice of treatment in 1994 must not only take into account the anticipated biological behavior of the cancer, but also the patient's physical, emotional, and rehabilitation needs. It is imperative that physicians use carefully worded instructions to allow patients to actively participate in this decision-making process. There is justified concern in this regard in geographical areas, institutions, and individual physician practices where the incidence of breast-conserving surgery is unexplainably low. Patients are better informed than ever before but are still easily influenced by individual physician bias. Most patients want to decide for themselves after weighing the therapeutic alternatives. This is a radical departure from the paternalistic approach of the past. The treatment of choice for a particular individual with early stage invasive breast cancer can be remarkably enhanced if the patient is provided access to the knowledge and experience of a multidisciplinary team of specialists, including the surgical oncologist, radiation oncologist, and plastic surgeon.

ACKNOWLEDGEMENTS: The author expresses his thanks for the work and cooperation of Ms Frances Ross of the Kentucky Cancer State Registry.

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Oat Cell Carcinoma of the Lung in Patients with CLL

P. Singh Rahal, MD; Victoria Cornelius, MD

Two malignancies in one patient was a remote possibility in the distant past, but currently more of these cases are being seen. At our institution, several patients with Chronic Lymphocytic Leukemia (CLL) were seen to develop oat cell carcinoma of the lung. The decreased immunity and B-cell dysfunction in CLL probably accounts for this secondary malignancy. We are presenting these cases to alert physicians of combined malignancies in a patient with increased aggressiveness of oat cell carcinoma.

CLL is a disorder of unknown etiology involving slowly proliferating cells, mainly B-lymphocytes. It has a genetic predisposition and is the most frequent familial leukemia without any clear inheritance pattern; it primarily affects the older age group (mean age group 60-70 years). The incidence in the USA is 0.003%. The cells associated with CLL are mature lymphocytes that accumulate in the body over time. The great majority of CLL lymphocytes are small cells that are in a quiescent state. CLL occurs more commonly in males than females and is rare in people of Chinese descent.

Oat cell carcinoma of the lung, also called small cell carcinoma of the lung, is progressively more common. It is primarily related to smoking and accounts for 25% of all lung cancers. It commonly begins as a central tumor but by the time diagnosis is made, 70% to 90% of patients have well-established micrometastasis.[1] It is the most aggressive cancer of the lung and can give rise to paraneoplastic syndromes.

Case 1

A 65-year-old white male with a history of diabetes mellitus and treated tuberculosis presented in June 1990 with increasing shortness of breath. The patient gave a history of smoking (132 pack-year) and a family history of unknown cancer. The chest x-ray revealed a questionable mass in the left lung. CT scan of the chest and abdomen showed splenomegaly and retroperitoneal adenopathy. The bone marrow biopsy at that time revealed a nodular aggregate of mature lymphoid cells, and the patient's disease was diagnosed as CLL. At that time, splenectomy was performed secondary to massive splenomegaly and no chemotherapy was given. He remained in remission. The patient presented again in December 1991 with a 6 to 8 week history of hemoptysis. Bronchoscopy was performed and biopsy revealed undifferentiated oat cell carcinoma of the lung. AFB and PPD were negative. CT of the head and abdomen did not show any metastasis. CT of the chest revealed post-obstructive atelectasis in the left lung. Bone marrow biopsy did not show any metastatic disease. At that time, chemotherapy with Adriamycin, chlorambucil, and cyclophosphamide was given along with radiation therapy. The patient later developed radiation pneumonitis. Throughout his disease course, his WBC and platelet count were within normal limits, although he remained anemic. The patient declared himself do not resuscitate (DNR) and died at home in July 1992, probably secondary to infection. His death occurred 7 months after the diagnosis of oat cell carcinoma.

Case 2

A 59-year-old white male presented in July 1984 with a history of non-tender axillary, inguinal, and submental lymphadenopathy. He also complained of spiking fevers and weight loss (about 10 lbs in 7 to 8 months). He had a history of alcohol abuse along with a 40 pack-year smoking history. Sternal biopsy and blood smear were finally determined to be consistent with CLL. CT of the abdomen showed periaortic and intrathoracic lymph nodes. He was started on chemotherapy with Cytoxan, vincristine, and prednisone, and he remained in remission until 1988 (a period of 4 years). He then developed severe thrombocy-

Dr Rohol is a resident at the University of Louisville. Dr Cornelius is on Assistant Professar of Internol Medicine; Assistant Professor of Pediotrics; and Progrom Co-Director af Internal Medicine in the Department af Medicine at the University of Louisville School of Medicine, Lauisville, KY.



Fig 1 — CXR showing left lower lobe infiltrate.



Fig 2—CT chest—showing constriction of left bronchus.

topenia (27,000 platelets) and was treated with high dose steroids. Because of increasing lymph node size, he was given a repeat course of chemotherapy in 1988. He later developed meningitis consistent with leukemic involvement and was treated with intrathecal methotrexate. In 1989, during follow up, the patient was noted to have a left hilar lung mass. Liver function tests were markedly abnormal and liver biopsy showed metastatic undifferentiated oat cell cancer. Bronchoscopy was not performed due to his poor status. It was thought that the patient developed primary oat cell carcinoma of the lung with secondary metastasis to the liver. The patient rapidly deteriorated and died of multiple organ failure 2 weeks after diagnosis of his second malignancy.

Case 3

This patient was a 63-year-old white male without significant past medical history. He had multiple admissions for recurrent pneumonia with high WBC counts. In 1986, a bone marrow biopsy confirmed a diagnosis of CLL. The patient remained asymptomatic and was not given any treatment.

He was admitted in May 1992 with high fevers, chills, night sweats, and a productive cough. He denied any history of hemoptysis, weight loss, or exposure to toxins. The patient had a 120 pack-year history of smoking. Chest x-ray revealed a left lower lobe infiltrate (Fig 1). His WBC count was 61,000 with 88% lymphocytes and 9% granulocytes. PPD and AFB were negative. Sputum showed *Hemophilus influenza* and the patient was started on ciprofloxacin. A repeat chest x-ray showed a mild to moderate pleural effusion. Thoracentesis revealed exudative fluid with negative cytology for malignant cells. The patient improved, had a clearing chest x-ray, and was discharged after 1 week.

Five days after being discharged, he was readmitted with increasing shortness of breath and low grade fevers. The patient was in labored breathing with a respiratory rate of 30 breath/minutes and a heart rate of 96/minute with a PaO_2 of 51 torr at room air. His chest x-ray showed a large pleural opacity on the left side obscuring the left hemidiaphragm. He was started on oxygen and broad spectrum antibiotics. Decubitus chest x-ray did not show any fluid layering. Sputum gram stain and culture were negative for organisms. A CT of the chest showed constriction of the left bronchus (Fig 2), with a large pleural effusion and a left hilar mass with mediastinal adenopathy. Bronchoscopy could not visualize the left bronchial tree secondary to constriction of the left bronchus. A chest tube was placed by surgery (Fig 3) and about one litre of bloody exudative fluid with a pH of 8.3 and a LDH of 1948 was collected. Pleural fluid cytology revealed oat cell carcinoma (Fig 4). His chest tube drained copious amounts of fluid, and his respiratory condition worsened. CT of the head and abdomen were negative for metastases, but a bone scan showed metastasis to the ribs and vertebrae. A bone marrow aspirate sample was positive for metastatic oat cell cancer. Chemotherapy with

cyclophosphamide, Adriamycin, and vincristine was initiated. At that time, his WBC count was 257,000 with a platelet count of 49,000. The patient deteriorated rapidly and died on the 19th day of hospitalization, 1 week after the diagnosis of metastatic oat cell carcinoma of the lung.

Discussion

The coexistence of two unrelated malignancies in one patient was unusual, but currently many cases are being reported. The course of oat cell carcinoma with CLL in our patients was aggressive; the average survival was 2 months after diagnosis, although average survival of oat cell carcinoma is 1 year.[2,3]

The onset of CLL is very insidious. The patient presents with vague complaints. Twenty-five percent of all patients are asymptomatic and the disease is diagnosed incidentally on routine CBC, while others present with enlarged lymph nodes and splenomegaly. Some patients have a benign course for a number of years, whereas in others, the disease progresses rapidly. Diagnosis of CLL is made by peripheral blood smears showing mature lymphocytes and is confirmed by bone marrow biopsy. No treatment is given to asymptomatic patients or stage 'O' patients (Table 1). Treatment should begin with the occurrence of troublesome symptoms. Chlorambucil is the most commonly used drug, but other alkylating agents like cyclophosphamide are also used. Corticosteroids are used to control acute symptoms such as autoimmune thrombocytopenia and hemolytic anemias. Local radiotherapy is sometimes used for enlarged lymph nodes or spleen. In current treatment, extracorporeal irradiation of blood is used in some instances to reduce white blood cell counts and organomegaly. The cause of death is usually infection. The average survival is 4 to 5 years.[4-7]

Table 1. Staging of CLL[14]

Stage 0 —	Peripheral lymphocytosis > 15,000
Stage 1 —	Stage 0 + lymphadenopathy
Stage 2 —	Stage 0/Stage 1 + splenomegaly
Stage 3 —	Stage 0/Stage 1/Stage 2 + Anemia Hb < 11.0 gm/dl (males) Hb < 10.0 gm/dl (females)
Stage 4 —	Stage 0/Stage 1/Stage 2 + Thrombocytopenia (Platelet count < 100,000)



Fig 3 — CXR — with left pleural opacity and chest tube on left side.

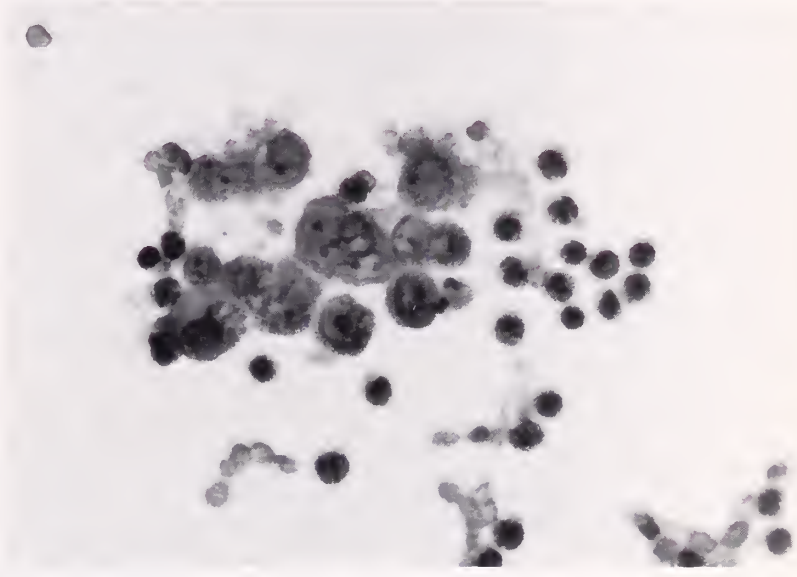


Fig 4 — Pleural fluid cytology showing oat cells.

CLL patients are thought to have a higher incidence of visceral malignancies, especially involving the lungs, the GI tract, and skin, lending support to the immune surveillance theory. This suggests that neoplastic cells are formed in many normal cells but are destroyed by a strong immune system. In CLL, there is B-cell dysfunction and thus decreased humoral-mediated immunity,

which explains an increased chance of secondary malignancies and recurrent infections. Second malignancies are increasing in frequency in CLL, with a reported incidence of solid tumors ranging from 2.5% to 34%.[8] There are documented cases of patients with oat cell carcinoma and CLL having metastasis to unusual organs like the parathyroid glands.[9]

In most cases, oat cell carcinoma presents with typical symptoms of dyspnea, pneumonitis, hemoptysis, or chest pain. Diagnosis is made mainly by histology. Sputum cytology is more likely to be negative in these patients, but bronchoscopy and transbronchial needle aspiration are the mainstays for diagnosis.[10, 11] Because cancer is usually metastatic by the time the diagnosis is made, TNM classification is of no help. It is defined as limited or extensive. Limited means that cancer is confined to one hemithorax and responds well to chemotherapy with complete remission (CR) in 40% to 60% of cases.[12, 13] Extensive disease is spread beyond one hemithorax and is almost uniformly fatal in 1 year in spite of chemotherapy, which is the mainstay of therapy.[2, 3] Very high levels of NSE (Neuron Specific Enolase) can be seen in oat cell carcinoma and can differentiate it from non-small cell carcinomas of lung with indecisive histology.[15, 16]

NSE, which is now becoming a tumor marker for oat cell carcinoma of lung, can also be seen in a few patients with CLL.[17] There are some future prospects for NSE to be used for earlier diagnosis of oat cell carcinoma. But in patients having CLL and oat cell cancer, NSE cannot be a helpful indicator for following the patients of oat cell carcinoma.

There is also a report that oat cell carcinoma can sometimes present mimicking acute leukemia, which is secondary to bone marrow involvement by primary oat cell carcinoma.[18] Metastasis to bone from oat cell carcinoma of the lung is a common event without any definite prognostic import other than that of disease outside the thorax. The reported rates of involvement range from 19% to 46%.[19-22]

Prophylactic and therapeutic use of intravenous immunoglobulins (IVIGs) for administration in patients with CLL and patients with oat cell carcinoma has been recommended. CLL is a suitable model for evaluating the prophylactic effects of IVIGs. It has been suggested by many studies that IVIGs reduce the frequency of respiratory infections in CLL patients. Also, the prophylactic course of IVIGs has been evaluated in patients with oat cell carcinoma. In a randomized prospective trial, it was observed that IVIGs given during the course of chemotherapy and radiation therapy will significantly reduce the frequency of infections. Many hematologists now treat CLL patients with modest doses of IVIGs at monthly intervals during the cold season.[23, 24]

Conclusion

Patients with CLL are at increased risk for a secondary malignancy, especially oat cell carcinoma of the lung, as presented in this article. Oat cell carcinoma in these patients with CLL was more aggressive, and they had a very short survival time after the diagnosis of oat cell cancer.

New tumor markers such as NSE might be used more in the future to make an earlier diagnosis of oat cell carcinoma. The prophylactic use of IVIGs has been shown to decrease the incidence of recurrent infections in CLL patients. But whether IVIG reduces the chances of secondary malignancies is not yet proven, and further exploration in this field is still needed.

ACKNOWLEDGEMENTS: Our special thanks to Dr Lung T. Yam for his clinical and manuscript assistance. We also thank Dr Korfige, Mr Koprowski, and Ms Rader for their help in preparing the manuscript.

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Diagnosis of Gastroesophageal Reflux in Pediatrics

Thomas C. Stephen, MD; M. K. Younoszai, MD; M. P. Massey, RN; Richard A. Fellows, MD

Drs Stephen and Younoszoi and RN Mossey are in the Division of Pediatric Gastroenterology, Department of Pediatrics, University of Louisville School of Medicine. Dr Fellows is in the Department of Diagnostic Radiology, Kosoir Children's Hospital, Louisville, KY.

Reprint requests to Department of Pediatrics, University of Louisville School of Medicine, Louisville, KY 40292 (Dr Younoszoi).

Gastroesophageal reflux (GER) may be normal, functional, *or* pathogenic. *Normal GER is of short duration and seen in all individuals. Functional GER, or effortless regurgitation, is common during infancy, causing no ill effects. Pathogenic GER causes diseases such as failure-to-thrive, coughing, choking, aspiration, apnea and/or bradycardia, esophagitis with irritability and excessive crying. Clinically it becomes imperative to distinguish normal and functional from pathogenic GER. The tests presently employed to detect GER are roentgenogram of the upper gastrointestinal tract (showing barium GER), scintigraphy of the esophagus after ingestion of a ^{99m}Tc labeled meal (indicating meal GER) and prolonged pH probe monitoring of the lower esophagus (depicting acid GER). There seems to be a controversy regarding the usefulness of these tests for the diagnosis of pathogenic GER. In the present study of 89 infants and children presenting with signs and symptoms of pathogenic GER, 70% had significant acid GER, while 36% and 17% had barium and meal GER respectively. No statistically significant correlations were detected between acid GER, barium GER, and meal GER. We conclude that these three tests probably represent different phenomena, and that prolonged esophageal pH monitoring should be considered the most reliable and gold standard for detection of pathogenic GER.*

Gastroesophageal reflux (GER) occurs when the pressure gradient across the gastroesophageal junction allows gastric contents to flow into the esophagus. Normally intraesophageal resting pressure is lower (10 mmHg) than that in the stomach, especially during inspiration when esophageal pressure becomes negative. This pressure gradient should allow free flux of gastric contents into the esophagus. It is the relatively high intraluminal pressure at the gastroesophageal junction that prevents ingested food from refluxing into the esophagus. The important structure that maintains the high pressure at the gastroesophageal junction is the lower esophageal sphincter. In normal full term infants, lower esophageal sphincter pressure has been found to be competent with normal resting pressures being somewhat higher than those in children and adults.[1-3] Gastroesophageal reflux is thought to be commonly due to inappropriate relaxation of a competent lower esophageal sphincter and less commonly due to an incompetent lower esophageal sphincter with continuous low pressure.[4] The etiology for the inappropriate relaxation of the lower esophageal sphincter is not known. In prematurely born infants lower esophageal sphincter pressure is low and appears to mature with increasing gestational age.[5]

Results of prolonged pH monitoring of the esophagus indicate that all normal individuals have some minimal degree of acid GER. This may be considered as *normal* GER. Reflux of feedings (regurgitation) is common in a large percentage of normal young infants, usually after feeding, and sometimes in large amounts. This could be considered as *functional* GER because it causes no ill effects. GER may be *pathogenic* when associated with failure to thrive from excessive vomiting, apnea and/or bradycardia thought to be secondary to bronchospasm induced by esophageal acidity, coughing, choking, chronic pulmonary disease from aspiration of refluxed gastric contents, and chronic abdominal pain resulting from esophagitis. Clinically it becomes imperative to distinguish normal and functional GER from pathogenic GER.

The tests presently used to detect GER are roentgenograms of the upper gastrointestinal tract which show barium reflux, scintigraphy of the esophagus after ingestion of ^{99m}Tc-labeled meal which indicates meal reflux, and prolonged (about 24 hour) pH probe monitoring of the lower esophageal region which depicts acid

reflux into the esophagus.

There seems to be controversy regarding the usefulness of these tests for the diagnosis of pathogenic GER. In the present study we determined the incidence of barium, meal, and acid GER in infants and children manifesting signs and symptoms compatible with pathogenic GER.

Subjects and their presenting signs and symptoms

Eighty-nine infants and children ranging in age from 3 months to 16 years (46 males, 43 females) with signs and symptoms of GER were included in the study. There were 32 infants (less than age 2) who mostly suffered from chronic vomiting, excessive crying and irritability, and/or other signs and symptoms of pathogenic GER described above. Of the 57 children (> 2 years of age) most presented with signs and symptoms such as nausea, vomiting, and chronic recurrent upper abdominal pain. Table 1 shows the frequency of the various signs and symptoms in the patients studied. Other diseases causing similar signs and symptoms were ruled out by urinalysis, complete blood count, and when appropriate, determinations of serum amylase, lipase, electrolytes, liver enzymes and stool examination for ova, parasites, stool cultures, hemoccult test, ultrasound of the abdomen, and computerized axial tomography of the head.

Table 1. Symptams in 89 infants and children studied

	# af Pts	% af Pts
Abdaminal pain	55	62%
Vamiting	55	62%
Nausea	20	22%
Irritability	18	20%
Failure to thrive	18	20%
Histary of recurrent Reactive Airway Disease	9	10%
Chest pain	8	9%
Hematemesis	7	8%

Methods of Study

Barium roentgenogram of the upper gastrointestinal tract (UGI x-rays): Young infants were given 90 ml of barium sulphate via nasogastric feeding tube, whereas older infants and children were given 150 ml-360 ml of the barium solution, usually in a bottle or cup, to drink. Once the stomach was full with the barium solution and the patient in supine position, fluoroscopy was used at 3-5 second intervals up to a maximum of 8 minutes to document barium GER into the esophagus. More than one episode of reflux into the esophagus during this time interval was considered indicative of barium GER. No abdominal compression or Valsalva maneuver was used.

Scintigraphy of the esophagus: All patients were subjected to gastric emptying study by scintigraphy. Subjects were fasted at least 6 hours prior to study. Five hundred μCi of ^{99m}Tc was incorporated into either the usual volume of formula that the infant was taking at home, or into 8 ounces of Meritene milk shake (Doyle-Sandoz Nutrition, Minneapolis, MN) for older children. The tracer was administered to young infants via nasogastric feeding tube so that little or none of the tracer was lost during the process of feeding. The upper abdominal region was scanned using Gamma Camera (Model #SOPHA DSX, Sopha Medical Systems, Columbia, Maryland) every 8 minutes for a 5-minute interval for a total period of 120 minutes. The esophageal region was thus scanned for a total time of 75 minutes during this period. During the scanning period any radioactivity over the esophageal area was considered positive for meal GER.

Prolonged pH monitoring of the lower esophagus: pH monitoring of the lower esophagus was conducted for 17 to 23 hours with a flexible pH probe connected to digitrapper (Synectics Mark II Gold, Irving, Texas). The pH probe was introduced through one nostril and was positioned about 4-5 cm above the gastroesophageal junction, which was measured during endoscopy. In the few infants who did not undergo endoscopy, the position of the pH probe was confirmed using posterior-anterior view roentgenograms of the chest. The digitrapper was calibrated to pH 7 and 1 using reference buffer solutions prior to use. The patients received the formula or regular food with no limitations in their activity. The data was analyzed with an IBM (model #8512-001) computer that generated a report summary indicating the number of acid refluxes (pH<4), and total time the esophageal pH was less than 4.0. The patient was considered to have significant acid reflux if the esophageal pH was less than 4.0 for more than 5% of the total recording time.

Table 2. Number of patient studies who were positive or negative for acid, barium and meal GER

	Positive	Negative
Acid GER	62	27
Barium GER	32	57
Meal GER	17	72

Results

The incidence of acid, barium, and meal GER did not vary between subjects less than and over 2 years of age and between male and female patients. The combined data are presented in the tables.

As indicated in Table 2, 62 patients (70%) showed significant acid GER, 32 (36%) demonstrated barium GER, and 17 (19%) had meal GER.

The incidence of barium and meal GER in patients positive or negative for acid GER and the incidence of meal GER in patients positive or negative for barium GER are shown in Table 3. Twenty-four children with significant acid GER showed barium GER, whereas 8 children negative for acid GER showed barium GER. No statistically significant correlation was observed between acid and barium GER ($\chi^2 = 0.33$). Similarly, 14 children positive for acid GER showed meal GER and 3 negative for acid GER showed meal GER, but no statistically significant correlation was observed between acid and meal GER ($\chi^2 = 0.9$). Nine patients showed both barium and meal GER, whereas 8 children showed meal GER despite negative barium GER. No statistically significant correlation was observed between barium and meal GER ($\chi^2 = 1.8$).

Table 3. The number of patients positive or negative for acid GER who were positive or negative for barium and meal GER, and the number of patients positive or negative for barium GER who were positive or negative for meal GER.

	Barium GER		Meal GER	
	(+)	(−)	(+)	(−)
Acid GER positive	24	38	14	48
Acid GER negative	8	19	3	24
Barium GER positive			9	23
Barium GER negative			8	49

Discussion

We found that only one-third of patients with signs and symptoms of pathogenic GER had barium GER. Similar observations have been reported by other investigators.[6-8] Arasu et al[6] reported upper GI x-rays to show GER in 15 of 30 infants and children presenting with symptoms of GER, while barium GER was not seen in 15 control patients. Euler et al[13] found that only 26% of their patients with symptoms of pulmonary disease had positive esophagogram for GER. Thus UGI x-ray seems to have a limited use in determining the presence of pathogenic GER, although it has been and continues to be used by physicians. UGI x-ray carries with it the risk of unnecessary radiation. The value of UGI x-rays is to make certain that structural defects are not the cause of the presenting signs and symptoms.

Similar to UGI x-rays, nuclear scintigraphy of the esophagus also has a limited role in the diagnosis of pathogenic GER.[6, 8, 9] The main limitation of UGI x-ray and esophageal scintiscan is that GER cannot be observed over prolonged periods of time and during normal activity. The fact that normal and functional GER occur more frequently during the first 2 hours after a meal than at other time intervals makes one cautious in making a diagnosis of pathogenic GER based on the results of a 2-hour postprandial test. A poor correlation between scintiscan and esophageal pH probe has also been reported before,[10] suggesting that these two tests may represent different phenomena.

In the present study, similar to the findings by other investigators, significant acid GER was found in the majority of patients. Thus prolonged pH monitoring of the esophagus appears to be the most reliable and has been considered as the gold standard test for pathogenic GER.[12-14] Prolonged pH monitoring of the lower esophagus is useful as a test for the detection of GER because in most individuals gastric contents maintain a low pH between meals and even after ingestion of meals. Thus the presence of acid in the esophagus indicates GER. In the few infants who may have GER of neutral gastric contents because of the presence of bile in the stomach, pH monitoring of the esophagus will not detect pathogenic GER. The frequency of reflux of bile into the stomach during infancy is unknown at this time. Obviously, the test is of no value in patients with hypo- or achlorhydria. The main advantage of this test over others is that GER of acid gastric contents can be

monitored for prolonged periods of time, such as 24 hours, or even longer if needed. The monitoring can be performed during normal activity, in different body positions, and during sleep. The correlation between events such as apnea, bradycardia, coughing, etc, and acid GER can be ascertained, and the duration of exposure of the esophageal mucosa to acid gastric contents can also be determined. Prolonged pH monitoring of the esophagus is most helpful in differentiating normal and functional GER from pathogenic GER.

In practice, a history of chronic effortless regurgitation in an infant with no significant discomfort and a normal physical examination and growth pattern is all that is necessary to make a diagnosis of *functional* GER. In infants with signs of discomfort, regurgitation, and significant vomiting, specific tests such as CBC and differential, urinalysis and urine culture, blood and urine metabolic screen, and other appropriate studies are needed to rule out organic causes of emesis. Further testing may be indicated if response to conservative management is poor, or vomiting becomes prominent and there is concern for the presence of *pathogenic* GER.

When an infant presents with excessive vomiting, an UGI x-ray is obtained to rule out swallowing abnormality, esophageal stricture, achalasia, hiatal hernia, gastric outlet obstruction, and malrotation. It should be pointed out that in some infants with significant GER documented by pH probe and showing esophagitis by endoscopy, UGI x-rays do not reveal GER.

Prolonged intraesophageal pH monitoring of the esophagus is now accepted as the most reliable available test for the diagnosis of pathogenic GER. In those patients in whom pH probe study is normal but pathogenic GER is still suspected because of symptomatology, other tests may be used to evaluate the functional integrity of the gastroesophageal junction and the esophageal mucosa, such as esophageal manometry, upper gastrointestinal endoscopy, and esophageal mucosal biopsy. With the advent of new devices that are able to simultaneously monitor esophageal motility, esophageal pH, and gastric pH over prolonged periods of time, it will be possible to improve the accuracy and specificity of tests used to detect pathogenic GER.

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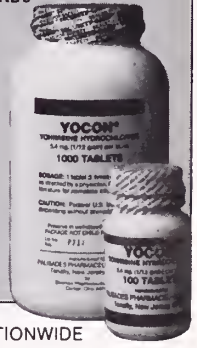
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3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85

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1994

JUNE

9-11 — 39th Great Smoky Mountains Pediatric Seminar, Park Vista Hotel, Gatlinburg, TN. Sponsored by The University of Tennessee Medical Center at Knoxville. Contact: Continuing Medical Education, 1924 Alcoa Highway, D-116, Knoxville, TN 37920; 615/544-9190.

23-25 — First Annual Meeting of the Southern Association for Family Practice, The Woodlands, Williamsburg, VA. Contact: Kathleen McLendon, Department of Education, 205/945-1840.

JULY

18-22 — Contemporary Clinical Neurology, Palmetto Dunes, Hilton Head, SC. Sponsored by Vanderbilt University Medical Center. Contact: Marilyn D'Asaro, 615/322-4030.

26-29 — Contemporary Medical Imaging XI, Hilton Head, SC. Sponsored by Vanderbilt University Medical Center. Contact: Sherri Culp, 615/322-4030.

28-30 — Seventh Annual Meeting of the Southern Association for Oncology, Jekyll Island Club Hotel, Jekyll Island, GA. Contact: Write to Linda Willingham, Coordinator, SAO, PO Box 190088, Birmingham, AL 35219-0088 or call 205/942-0530.

AUGUST

4-5 — Functional Endoscopic Sinus Surgery Workshop 1994, Vanderbilt University Medical Center, Nashville, TN. Sponsored by Vanderbilt University Medical Center. Contact: Sherri Culp, 615/322-4030.

19-21 — Southern Orthopaedic Association 1994 Annual Meeting, The Southampton Princess, Bermuda. Contact: Linda Willingham, 205/945-1848.

SEPTEMBER

10-13 — Seventh Annual Update in Internal Medicine, The Ohio State University, Columbus, OH. Co-sponsored by the Department of Internal Medicine and the Center for Continuing Medical Education at University Medical Center. Contact: Sandi Latimer, University Hospitals Communications, 614/293-3660.

23-25 — Annual Pulmonary/Critical Care Medicine. Contact: Marilyn J. D'Asaro, Program Coordinator, Vanderbilt C.M.E. Division, 615/322-4030.

24 — Eleventh Annual Ophthalmology Seminar: Uveitis Update. Audubon Regional Medical Center, Louisville, KY. Contact: Cathy Edens, 240 Audubon Medical Plaza, Louisville, KY 40217; 502/636-2823.

29 — October 1 — Lasers in Otolaryngology-Head and Neck Surgery, Vanderbilt University Medical Center, Nashville, TN. Sponsored by Vanderbilt University Medical Center. Contact: Kimberly Sammons, 615/322-4030.

OCTOBER

28-29 — Laryngeal Video Endostroboscopy, The Village at Vanderbilt, Nashville, TN. Sponsored by Vanderbilt University Medical Center. Contact: Kimberly Sammons, 615/322-4030.

NOVEMBER

15 — Laser Assisted Uvulo-Palatoplasty — A New Treatment for Snoring, The Village at Vanderbilt, Nashville, TN. Sponsored by Vanderbilt University Medical Center. Contact: Wendy Prostick, 615/322-4030.

DECEMBER

2-3 — 20th Annual High Risk Obstetrics/Gynecology Seminar. Contact: Marilyn J. D'Asaro, Program Coordinator, Vanderbilt C.M.E. Division, 615/322-4030.

1995

JANUARY

28-February 4 — Eighth Annual Diagnostic Radiology/Medical Imaging. Contact: Marilyn J. D'Asaro, Program Coordinator, Vanderbilt C.M.E. Division, 615/322-4030.

Mark your calendar today!



Protect and Preserve

Congressman Romano Mazzolli closes his career in the House of Representatives. Senator George Mitchell chooses not to run for his third term, surrendering the Democratic Majority leadership in the Senate. Secretary of Defense Les Aspin resigns his position at the time of his ascendancy to national and international prominence. Our colleagues in medicine, after reaching their sixties, or in some cases, fifties, elect to close their medical practice life and opt for various alternatives. Some have chosen to fully retire, accepting an official conclusion to their employed life. Others substitute institutional work, mimicking their previous career sans practice worries. A few changed their path, following academic pursuits or religious callings.

The 1960s had a generation of drop outs, of rebels, of disillusioned youth and some older. The 1990s have another generational phenomenon — the tired. Listening to those in public life on the news, I hear the same echoes in the doctor's lounge, and I feel the energy dissipation. Their enthusiasm, so infectious to the junior physicians who followed them, has faded. Interest in dynamic medicine is replaced by concern about not losing the touch and feel for the knowledge already committed.

Nearing 50 and full of responsibilities, I have the perspective of both these phenomena. My education and some growing up took place for the most part in the 60s. Buffeted around by waves of protest and threats of racial and foreign war, I had to focus and refocus on the job of education, and insert enjoying the process and the times as well as I could. That time behind me, I engineered my career to build a professional life, and gladly accepted the help and hands of my senior physician colleagues. To my chagrin now, these same people are leaving the arena, and not infrequently before their time. They are surely entitled to make those choices, but what is happening in medicine and to medicine has initiated, nurtured, and solidified these alternatives. Managed care, capitation, provider taxes, health coalitions, and many more slogans whip in front of us like a cold north wind. Bureaucratic swords, these programs of government control, are thrust into the medical body, with the power coming from those alien to us and determined to manipulate our destiny. Practices are examined by the IRS for fiscal errors, by OSHA for employment transgressions, by CLIA for laboratory miscues, and by regulatory agencies yet to be born. No wonder that our colleagues, faced with this, grow tired of their professional life in medicine, and cannot find a way back to the simpler days of practice. Tired in the same way that many of our elected and appointed representatives are when faced with the press and with inspection of everything they do and feel.

"We who are left should vigorously defend our professional life. Medicine still has the joy of discovery, of helping, of enterprise, and of doing good for so many. . . . The lesson to be learned from our senior colleagues is protect and preserve your enthusiasm."

We who are left should vigorously defend our professional life. Medicine still has the joy of discovery, of helping, of enterprise, and of doing good for so many. That feeling when the patient gets well, and gives thanks for our education, dedication, and accomplishments is infectious. It spreads to our staffs, our hospitals and clinics, overcoming the paper work deluge and the contamination from "payers." The lesson to be learned from our senior colleagues is protect and preserve your enthusiasm. Medical work has numerous forms, whether it be the practice of the trade, or writing, or speaking to others, or teaching the young and anxious. Our problems in the public arena and the insults from insurance and governmental players need not be neglected or feared. All our energy, that precious commodity that fuels our lives, should not be totally consumed fighting all these battles. There are enough of us around to grab the line and help pull against these forces. Enjoy medicine, both the doing of it and the learning more about it, because that is what medicine is about.

Stephen Z. Smith, MD

TO HELP OTHERS WE MUST HELP EACH OTHER

As physicians, we are responsible for the health and well-being of those around us. When a physician develops problems that impair his or her ability to carry out professional responsibilities, it's up to us to help.

The goal of the impaired physicians program of the Kentucky Medical Association is to assist physicians and their families who are demonstrating problems associated with the inappropriate use of alcohol and/or drugs, emotional and mental disability, or the aging process.

The committee supports a policy of early identification, by self, colleagues, or others, and active intervention to bring prompt assistance to the physician while ensuring the welfare of his or her patients. The policy is designed to ensure referral to acceptable treatment resources with the aim of full rehabilitation.

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Joyce Clark

Our Youth, Our Future

"Today more than ever our Alliance needs to assess their involvement in programs and legislative campaigns that will benefit our youth. . . . Through these efforts we will send a strong message. A message that we care about the health and safety of our youth."

In recent years, crimes against and involving children have escalated dramatically in this country. Our children are in jeopardy today of being involved in some way with violence as never before. The future of our youth and our country is at risk.

The faces of missing children from toddlers to teenagers stare at us from milk cartons and fliers posted in windows and on utility poles. Networks of organizations stretch nationwide to help with the desperate efforts of parents to locate young victims of kidnappings and murders. Tenderloin streets and park encampments are filled with youngsters who were tricked by con artists and drug dealers into believing — that life improves with a needle, a liquid or a powder, and that things are better away from home. The ceaseless flood of grim news stories about all the things happening to our youngsters is enough to give any parent a touch of paranoia.

Statistics show that all areas of crime have increased. Since 1989, domestic violence, including child abuse in homes, has shown a steady increase. This abuse includes physical, mental, and sexual. It does not seem to be confined to any economic group, and many times, it is alcohol or drug related.

Sex related crimes have increased. Studies done by the Kentucky Department of Education 3 years ago showed that 40% of all freshmen in high school have had at least one sexual encounter. At least 71% of all seniors are sexually active, having had three or more partners. Some of these encounters are the results of sexual abuse in the home, or date rape. At least 20% had used no form of contraception or protection to help prevent sexually transmitted diseases. The percentage of these encounters that were drug or alcohol related is unknown. One third of these youngsters had more than four partners in a 3-month period of time. In 1991 there was one forceable rape every 5 minutes. For the fiscal year 1990-1991, the Kentucky state department statistics show that teenage pregnancy cost Kentucky $277,941,000 including food stamps, AFDC, and Medicaid.

Violence involving weapons has shown a dramatic increase over the last 5 years. In 1991 our state had one

violent crime every 17 seconds, one murder every 21 minutes. Fifty-eight percent of all juvenile arrests were class 11 crimes: crimes involving weapons, sex offenses (not rape), alcohol, drugs, robbery, and vandalism. Violence against law enforcement officers has tripled over the last 3 years. Records show that violence and crime as a result of role playing of violent crimes viewed on TV or at the movies has increased.

Violence is increasing in our society and, unfortunately, the effectiveness of our criminal justice system is limited.

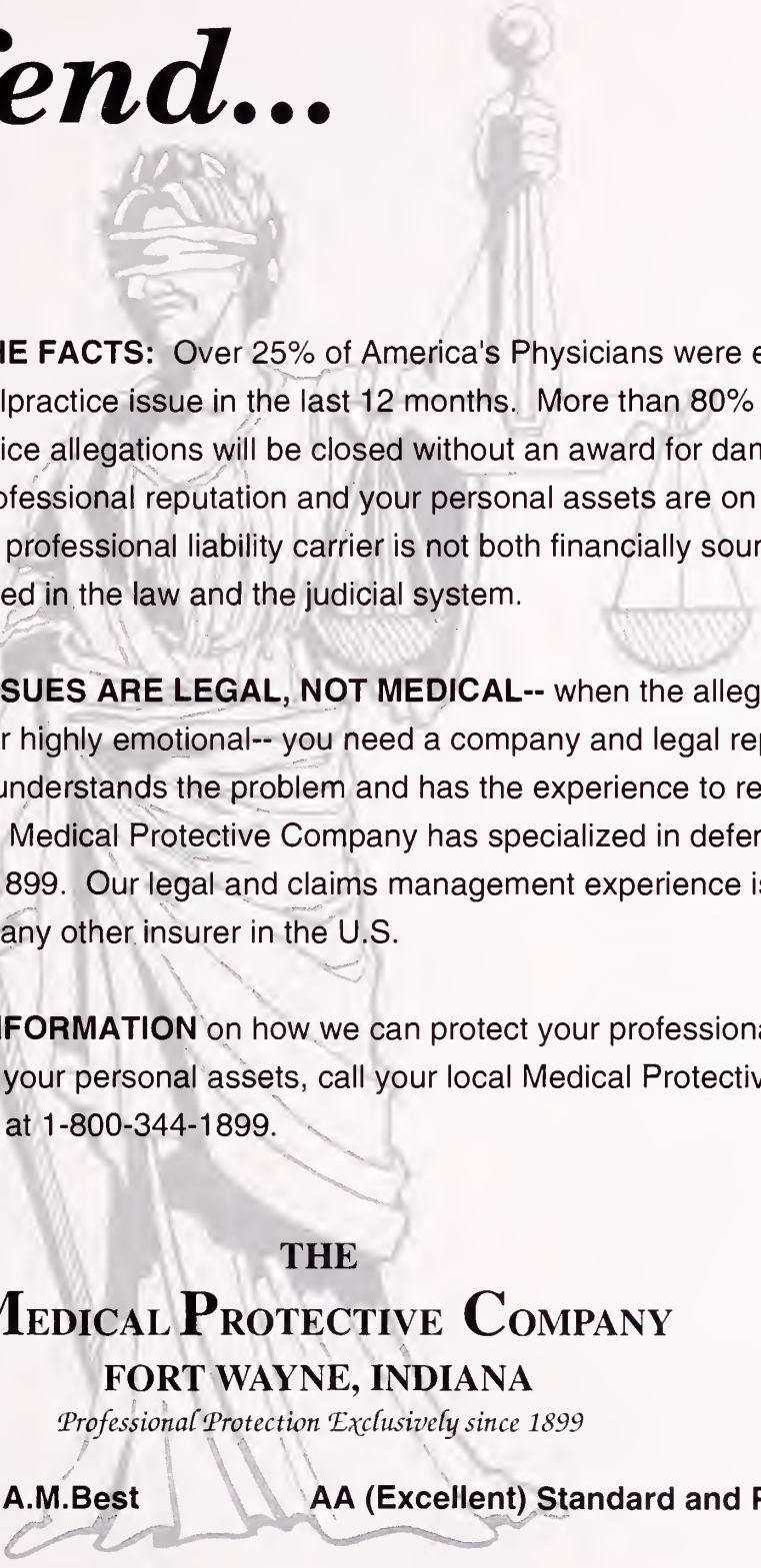
A lot of transition and encounters take place in a child's life. All children are curious and will experiment. Didn't you? Children are mimics, therefore we must take a close look at the violence and sex being shown on TV and in the movies. We must make educational programs dealing with drug abuse, alcohol, and tobacco more available. Programs on self protection and firearms, and programs teaching sex education and prevention of sexually transmitted diseases are a must. Children must be taught responsibility and correct choices.

Today more than ever our Alliance needs to assess their involvement in programs and legislative campaigns that will benefit our youth. We must become a united front working in coalition with other community agencies, schools, churches, and civic groups to establish programs that will educate our youth and help them to make healthy and responsible decisions. We must organize campaigns that will clean up advertisements, TV, and the movie industry. The Alliance must actively support legislation that will support our efforts and quality health care. Through these efforts we will send a strong message. A message that we care about the health and safety of our youth. After all, our youth is our future.



KMA Alliance President

...a promise to defend...



HERE ARE THE FACTS: Over 25% of America's Physicians were embroiled in a malpractice issue in the last 12 months. More than 80% of those malpractice allegations will be closed without an award for damages. Your professional reputation and your personal assets are on the line when your professional liability carrier is not both financially sound *and* experienced in the law and the judicial system.

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People

Mohammed Mohiuddin, MD, has been named chair of the Department of Radiation Medicine for the University of Kentucky College of Medicine. Dr Mohiuddin's previous academic appointment was as vice chair and professor of the Department of Radiation Oncology and Nuclear Medicine at Jefferson Medical College of Thomas Jefferson University in Philadelphia. Dr Mohiuddin is a diplomate of the American Board of Therapeutic Radiology. He is also a fellow of the Royal College of Radiologists (England) and holds a DMRT diploma in medical radiology from the Royal College of Physicians and Surgeons in London.

Stanley R. Freger, PhD, a Louisville psychologist, university professor, and host of the 84 WHAS radio talk show, *Let's Talk,* has been reelected president of the Kentuckiana Chapter of the United Ostomy Association. Dr Frager is past president of UOA and a former member of the Board of Directors. As an author and speaker who has survived cancer, he has devoted his life to motivating and encouraging others who face adversity. This is the subject of his book, *The Champion Within You.*

Ronald L. Levine, MD, a Louisville OB-GYN, was elected to the advisory board of the American Association of Gynecologic Laparoscopists. Dr Levine was installed at the annual meeting held in San Francisco. The AAGL is an international organization serving 7,000 members.

George H. Zenger, MD, Louisville, received a 3-year appointment as Cancer Liaison Physician for the Audubon Regional Medical Center Cancer Program. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons.

James L. Wittliff, PhD, has returned from sabbatical leave in Vienna, where he was appointed Inaugural Guest Professor in the Institute of Applied Microbiology in a new $80 million biotechnology center established as a joint effort of the Austrian government and the University.

Working in protein technology, Dr Wittliff has instituted large-scale production of sex hormone receptors as part of a long-term collaboration between the Institute and his laboratory in the J. Graham Brown Cancer Center in Louisville. The joint effort is part of a major multi-disciplinary effort between Dr Wittliff's lab, molecular biologists at SmithKline Beecham in Philadelphia, and Berkeley Antibody Company to develop new probes and therapeutics for cancer patients.

Richard A. Gould, MD, FACS, was recently elected as a Specialty Fellow in Urology of the American Academy of Pediatrics. There are presently 255 Fellows in the United States, all of whom devote the majority of their practice to the care of children. Dr Gould is Clinical Assistant Professor of Urology at the University of Louisville School of Medicine.

UPDATES

UK College of Medicine Ranked in Nation's Top 10 for Fourth Consecutive Year

The University of Kentucky College of Medicine is among the top 10 primary care medical schools in the US for the fourth consecutive year, according to *U.S. News and World Report.* UK was number eight on the list of best primary care schools (out of 126 medical schools), with a rank of 83.8 out of a possible 100. In that category, UK was ranked sixth for its academic reputation among academics. It was listed as receiving $20,112,973 in research funding from the National Institutes of Health in 1993.

"This ranking acknowledges our emphasis on research and clinical service," says **Dr Emery Wilson,** Dean of the College of Medicine. "At the same time, we are also committed to responding to societal needs by emphasizing more primary care, preventive care, and cost-containment."

Each year *U.S. News and World Report* surveys graduate school programs in 11 academic fields. Medical schools receive a ranking based on two equally weighted surveys of academic reputation, one conducted among top medical school deans and the other among intern-residency directors.

U of L Using New Tool in Fight Against Colon, Rectal Cancer

A recent report from the University of Louisville states that the school has taken part in a national study of a procedure that proved 85% effective in detecting recurring colon and rectal cancer in patients.

U of L is one of 10 schools that tested immunoscintigraphy, a scanning test that allows doctors to find colorectal tumors that may be missed by other procedures such as CAT scans. The procedure involves injecting patients with radioactive antibodies that attach themselves to cancer cells. Doctors then use a nuclear medicine gamma camera to detect the radiated cells. The procedure is used primarily on patients who already have been diagnosed with colorectal cancer to

help surgeons determine the extent of the disease and whether surgery is appropriate.

U of L surgeon **Susan Galandiuk, MD,** and doctors at the University of Chicago and Sansum Medical Clinic in Santa Barbara, CA, headed the national study.

According to the study, published recently in the journal *Diseases of the Colon and Rectum*, the immunoscintigraphy scans often detected recurrences after standard tests found none; the scans also found additional tumors in patients believed to have only isolated recurrences. The researchers found the scans were beneficial or very beneficial for two-thirds of the patients in the study.

The immunoscintigraphy test was developed by Cytogen Corp and is being co-promoted in the United States by Cytogen and Knoll Pharmaceutical Co. The scan costs about $2,000, which includes hospital costs and the price of radioactive material used in the procedure.

For more information, call Dr Galandiuk at U of L, 502/852-4568.

HIV Infection Clinical Practice Guidelines

New guidelines have been released by the US Department of Health and Human Services Agency for Health Care Policy and Research. The purpose of the guidelines is to improve the ability of family physicians, pediatricians, and other primary care physicians to provide critically important early care for persons recently infected with the human immunodeficiency virus. The guidelines were developed by a private-sector panel of physicians, dentists, nurses, social workers, and physician assistants.

Copies of *Early Evaluation and Management of HIV Infection* may be obtained free of charge by calling 1/800/342-2437.

Medical Necessity For Assistant At Cataract Surgery

The Kentucky Medical Review Organization (KMRO), as the PRO for Kentucky, has received clarification from the Health Care Financing Administration (HCFA) regarding preprocedure review of the medical necessity for an assistant at cataract surgery. PROs are now to conduct preprocedure review for CPT code 66930 for services rendered after December 31, 1993. This code was formally reviewed by PROs but deleted from the list of codes subject to preprocedure review for calendar year 1993.

The codes subject to the PRO prior approval process for 1994 are:

66852	66940
66920	66985
66930	66986

Carriers received notice of this change earlier this year, and will make payment for assistants at surgery for CPT code 66930 when PRO prior approval is received, and the date of service is after December 31, 1993.

Although carriers were instructed to inform physicians about the payment for this code, KMRO has notified the KMA to assure appropriate dissemination of this information to our members.

Questions concerning this information should be directed to **William G. Davis, Jr, MD,** Medical Director, at 502/339-7442.

4th Annual CME Seminar

The KMA CME Committee is sponsoring its 4th Annual Seminar on the continuing medical education accreditation process. The Seminar is designed for physicians and nonphysicians who are actively engaged in the design and/or implementation of continuing medical education programs. In particular, this program is beneficial for directors of continuing medical education, CME program administrators and staff, administrative assistants, physician CME chairpersons, CME Committee members, and university and medical center CME program directors and staff.

The Seminar is scheduled for May 26, 1994, at the Hurstbourne Hotel and Conference Center in Louisville from 9:00 AM to 3:30 PM. The cost is $50 per participant, which covers continental breakfast, lunch, and seminar materials.

If you would like to attend the CME Seminar, please contact the KMA Headquarters Office at 502/426-6200.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Bourbon

Matilal C. Patel, MD — ORS
328 Bourbon Acres Rd, Paris 40361
1967 U of Baroda

Clay

Joseph J. James, MD — IM
103 Main St, Box 305, Manchester 40962
1973, U of Sri Lanka

Fayette

David P. Kramer, MD — AN
4822 Hartland Pky, Lexington 40515
1989, U of Texas

Melanie D. Mattson, MD — IM
114 Stone Rd #A, Lexington 40503
1987, Louisiana State U

Gregory T. Snider, MD — FP
1221 S Broadway, Lexington 40504
1989, U of Kentucky

Floyd

Steven A. Conrotto, MD — FP
PO Box 600, Hagerhill 41222
1989, Oral Roberts

Franklin

Kevin D. Perdue, MD — ORS
101 Medical Hgts Pk #F, Frankfort 40601
1988, U of New Mexico

Jefferson

Naser M. Ammash, MD — C
2500 River Oak Dr, Louisville 40206
1986, American U of Beirut

Denise F. Bratcher, DO — PD
2108 Edgehill Rd, Louisville 40205
1986, Col of Osteo Med, Kansas City

Corey M. Cohen, MD — EM
3 Normandie Vlg, Louisville 40205
1990, U of Louisville

Deirdre A. Durkis, MD — AN
747 S 5th St #23, Louisville 40203
1989, U of Missouri

Eugene C. Fletcher, MD — PUD
530 S Jackson #A3Lo1, Louisville 40292
1971, Temple

Flavio D. Manela, MD — IM
1760 Casselberry Rd, Louisville 40205
1981, U of Rio de Janeiro

James L. Nadler, MD — PM
642 S 2nd St #912, Louisville 40202
1980, U of Michigan

Seth W. Pois, MD — P
1169 Eastern Pky, Louisville 40217
1988, U of Louisville

Julia M. Robertson, MD — P
5804 Brittany Valley Rd, Louisville 40222
1979, Case Western

Michael E. Simons, MD — IM
838 E Muhammad Ali #C, Louisville 40204
1987, U of Louisville

Michael D. Tarantino, MD — PD
601 S Floyd #500, Louisville 40202
1987, U of Wisconsin

Caroline S. Willette, MD — PD
1519 Sylvan Way, Louisville 40205
1987, U of Texas

Knox

Jeffry A. Belknap, MD — IM
PO Box 940, Barbourville 40906
1970, Medical U of South Carolina

Leslie

Roy Varghese, MD — IM
100 Hospital Dr, Hyden 41749
1964, Trivandrum Med Col

Marshall

Thornton E. Bryan, Jr, MD — FP
PO Box 1055, Calvert City 42029
1954, U of Louisville

Northern Kentucky

Ted G. Pappas, MD — PD
811 Arlington Rd, Park Hills 41011
1989, U of Kentucky

Rowan

Seigfred P. Jalalon, MD — EM
St Claire Med Ctr, Morehead 40351
1972, Cebu Inst of Med



In-Training

Jefferson

Geoffrey L. Hulse, MD — ORS
J. Scott Kasteler, MD — D
Kaycia L. Vansickle, MD — P
Suzanne R. Yoder — P

Montgomery

Richard A. Hall, MD — IM

Perry

David P. Bosomworth, II, MD — FP
Charles J. Bradac, Jr, DO — FP
Jacqueline C. Eugenio, MD — FP
John P. Scanlon, DO — FP

DEATHS

John R. Woodyard, MD
Covington
1916-1994

John R. Woodyard, MD, a retired otolaryngologist, died February 20, 1994. Dr Woodyard was a 1945 graduate of the University of Cincinnati College of Medicine and a life member of KMA.

Willis P. McKee, MD
Shelbyville
1915-1994

Willis P. McKee, MD, a retired surgeon, died March 14, 1994. A 1939 graduate of the University of Louisville School of Medicine, Dr McKee was a life member of KMA.

John R. Jones, MD
Corbin
1933-1994

John R. Jones, MD, an orthopedic surgeon, died March 30, 1994. Dr Jones was a 1957 graduate of the University of Louisville School of Medicine and an active member of KMA.

AWARDS NOMINATIONS

The KMA Awards Committee is accepting nominations for the two highest awards the Association presents. The Distinguished Service Award is presented annually to a member of the Association based on the following criteria:

- **Contributions to organized medicine (including membership in county society, attendance of county and state meetings, service on committees, leadership as an officer, etc.)**
- **Individual medical service**
- **Community health, education and civic betterment**
- **Medical research**

The nominee may qualify on any one or all combinations of these points. Reasons for the nominations should be clearly stated.

The Kentucky Medical Association Award is presented to an outstanding lay person in Kentucky each year in honor of his or her outstanding accomplishments in the field of public health and/or medical care.

The Awards Committee will have the responsibility to choose recipients of the KMA Distinguished Service Award and the Kentucky Medical Association Award. Any county society or individual member may suggest nominees to the committee.

The awards are presented at the President's Luncheon during the annual meeting.

AWARD NOMINATION FORM

Name: _____

Address: _____

Birth Date: _____ Place: _____

Marital Status: _____

Spouse's Name: _____

Children: _____

☐ Distinguished Service Award (Physician)

☐ KMA Award (Lay Person)

Education: _____

Military: _____

Membership in Professional Organizations: _____

Membership in Civic Organizations: _____

Honors and Awards: _____

(Describe nominees qualifications and other pertinent information which the Awards Committee may consider in making its decision.

Name of Person or Group Submitting Nomination: _____

Address: _____

Phone: (Home) _____

(Office) _____

Please fill in and mail to: KMA, Attn: Awards Committee, 301 N Hurstbourne Pky, Ste 200, Louisville, KY 40222

Deadline for receiving nominations is July 15.

APPLICATION FOR SCIENTIFIC EXHIBITS

Kentucky Medical Association
1994 Annual Meeting

Commonwealth Convention Center, Louisville, KY
September 20-22

1. Title of exhibit _____

2. Name(s) of exhibitor(s) _____

   Address _____

   Professional title _____

3. Institution if other than exhibitor _____

4. Amount of backwall footage required _____

   (The draped booth has 4′ side walls. This footage should not be included in backwall footage required). TABLE DESIRED? _____

   (Table 2′ deep x width of backwall (footage) ELECTRICAL OUTLET DESIRED? _____

5. Will summary printed matter be available or obtainable for the interested physician? _____

6. Indicate sources of assistance provided to you in connection with this exhibit _____

7. Has this exhibit been displayed before? If so, when & where? _____

   _____

8. It is required that you attach a rough sketch or photograph and a brief outline of your exhibit to include: (a) content of the presentation and (b) the method, eg, equipment to be used.

Date _____ _____

Signature of Applicant

Fill out and mail to:
RICHARD A. KIELAR, MD, Chairman
Scientific Exhibits Committee
Kentucky Medical Association
301 N Hurstbourne Pky, Ste 200
Louisville, KY 40222

The Kentucky Medical Association welcomes and supports scientific exhibits as a facet of continuing postgraduate education.

Applications for space should be received before June 15, 1994.

- **COMMERCIALISM, such as utilizing the name of sponsoring organization or facility, either on the exhibit or in printed materials, is PROHIBITED.**
- **KMA provides, without cost to the exhibitor, one 2 ft. table, bracket lights and a title sign.**
- **Spotlights, view boxes, furniture, decorations, etc, may be furnished by the exhibitor or may be rented, if desired, by applying directly to the George E. Fern Company, 3752 Crittenden Dr, Louisville, Kentucky 40209.**
- **Transportation and erection costs are the responsibility of the exhibitor.**
- **Exhibit must be attended during intermissions to answer physicians' questions. It is also desirable to have someone in attendance throughout the program.**
- **Equipment which will create noise must not be used during the general sessions and, at other times, must be controlled by head or earphones or a muffling device.**
- **Exhibit must be dismantled and removed by 4:00 PM, Thursday, September 22, 1994.**
- **Exhibit space is strictly limited to footage and space allotted. No exhibit may extend into the aisle.**

Commonwealth Convention Center and the Kentucky Medical Association or its agents cannot guarantee against loss or damage and will assume no liability for damages nor guarantee the exhibitor against loss of any kind. The exhibitor agrees, with the Association, to be responsible to the Commonwealth Convention Center for damages that may occur as a result of the exhibitor's use of the facility.

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates to KMA members: $10 per insertion up to 50 words, 25¢ each additional word. To non-members; $30 per insertion up to 50 words, 25¢ each additional word.

Send advance payment with order to: The Journal of KMA, 301 N Hurstbourne Pky, Ste 200, Louisville, KY 40222.

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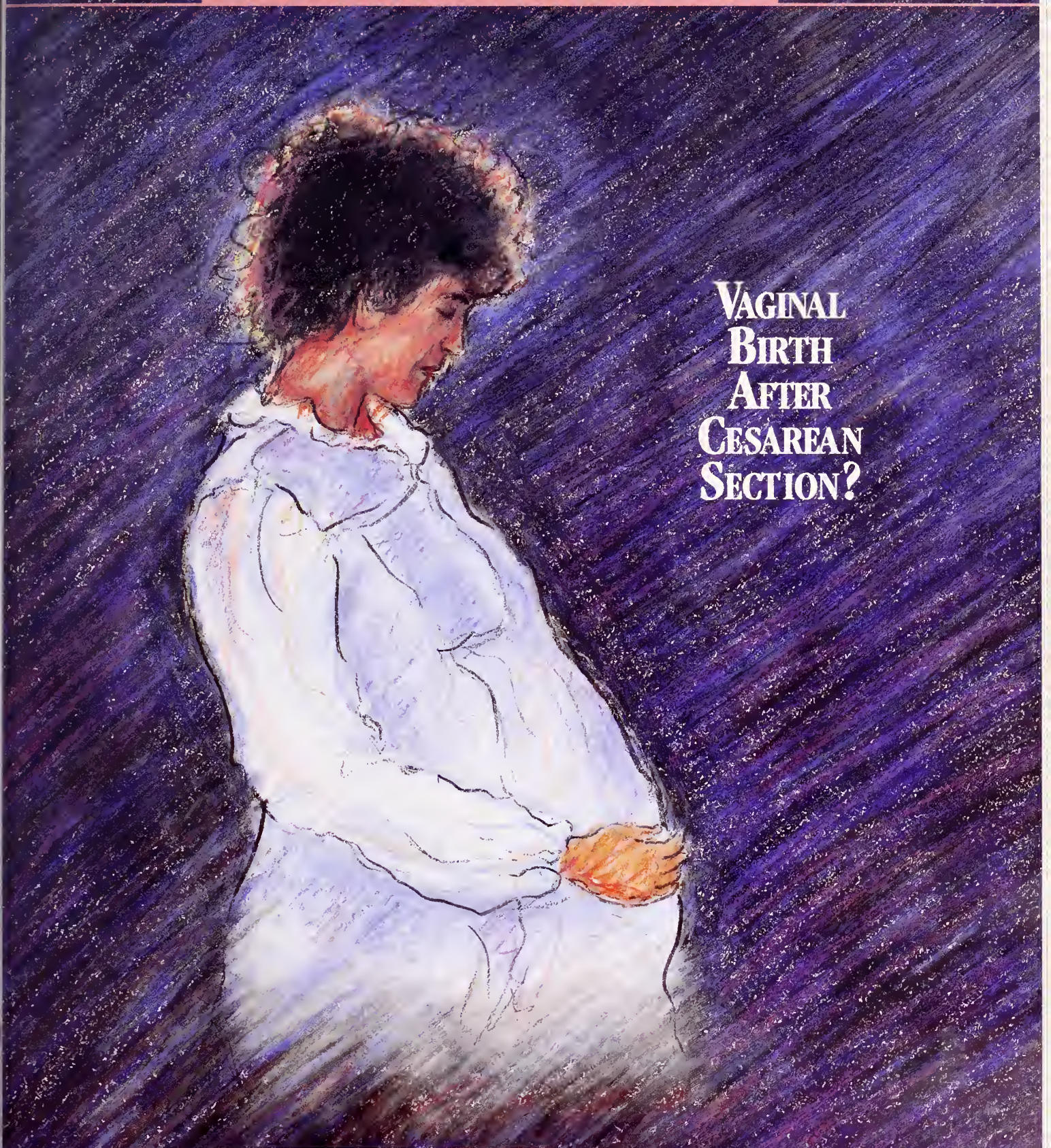
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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Second-class postage paid at Louisville, KY and additional offices. Yearly subscription rates: $25 domestic; $30 foreign. Single issues $3 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association*, 301 N Hurstbourne Pkwy, Suite 200, Louisville, KY 40222-8512. EDITORIAL AND ADVERTISING: Telephone 502/426-6200.

Listed in Index Medicus. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

National advertising representative: State Medical Journal Advertising Bureau, Inc, 11437 W 106th St, Overland Park, KS 66214, phone 800/788-2360.

The *Journal*, its editors, and the Kentucky Medical Association do not assume responsibility for the opinions and statements of its contributors and advertisers. The *Journal* reserves the right to make the final decision on all content and advertisements.

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Strength in Unity



Ardis D. Hoven, MD

Vince Lombardi, the inspirational coach of the Green Bay Packers, once said, "Build for your team a feeling of oneness, of dependence on one another, and of strength to be derived by unity."

The close of the 1994 General Assembly in Frankfort brought with it successes and disappointments, but certainly it emphasized the strength of oneness demonstrated by members of the Kentucky Medical Association, their spouses, and the staff and leadership of our medical association. A special word of thanks at this time to our lobbyists: Don Chasteen, John Cooper, William Doll, and David Carby for their long and tortuous hours in the Capitol working on our behalf and doing it with great integrity and knowledge. I consider it a special privilege to work with these gentlemen who provided sound advice and consummate wisdom for those of us entering the political arena with some fairly naive ideas about how problems should be resolved. Wally O. Montgomery, MD, as Chairman of the Legislative Quick Action Committee, and the other physician members worked diligently also on your behalf during this session.

To see the unified activity of physician members throughout the Commonwealth was extremely important, emphasizing the need to be aggressive, persistent, and determined in delivering our message to the members of the Legislature, and that message was clearly heard! The debate on the provider tax, rate setting, and the all-powerful health care policy board was decidedly affected by your activities. Although the provider tax remains in place for the time being, the resistance to increasing the tax (as endorsed by the Governor) and the closeness of the vote clearly demonstrates your effectiveness. Maintaining a strong communication link with the membership was likewise crucial in this process, and I personally would thank Mr Robert Cox and the entire staff of KMA for their timely communications and newsletters that kept us all up-to-date and knowledgeable.

As I have traveled throughout the state thus far, I am convinced that physicians, many for the first time, are seeing the need for organized medicine and their active participation, and our membership increases reflect this trend.

The challenge of health systems reform in the state is by no means over. A special session this month dealing with the budget will most likely again fuel the debate over the funding of Medicaid and Medicaid reimbursement. The Governor's desire to add 201,000 people to the Medicaid rolls will surface, emphasizing again government's unwillingness to fund indigent care in this state in an equitable and fiscally responsible way. I urge all physicians to continue the dialogue with your legislators and hold them accountable for their actions and votes.

"The close of the 1994 General Assembly in Frankfort brought with it successes and disappointments, but certainly it emphasized the strength of oneness demonstrated by members of the Kentucky Medical Association, their spouses, and the staff and leadership of our medical association."

The provider tax continues to be a major concern for your leadership and decisions regarding the "next step" will be forthcoming, pending the appeal for rehearing at the Kentucky Supreme Court. Considerable effort has been expended on multiple fronts and will continue. We are dedicated to pressing this issue as mandated by the KMA House of Delegates.

Thank you for your dedication to unity and strength as we continue as advocates for our patients and for the profession of medicine.

Ardis D. Hoven, MD
President

We Agree.

Every state medical society, 64 medical specialty societies, and the American Medical Association agree that any health system reform legislation must contain the principles outlined in the letter below:

February 23, 1994

Dear Senator/Representative;

As physician organizations, we agree on the need for health system reform legislation that gives every American universal coverage for health care and effectively controls rising health costs, while ensuring quality patient care. These principles have been articulated by numerous medical organizations in their various health system reform policies and proposals. They remain the foundation of our legislative agenda, which is to enact laws that assure universal coverage for a standard set of health benefits, regardless of employment or economic status.

We believe that any measure adopted by the Congress should:

- Achieve universal coverage through a program where responsibility is shared by employers, individuals, and government in paying for health care coverage.
- Assure that every American has his/her choice of health plans, physicians, and other providers.
- Establish competition in the marketplace as a method of slowing the rate of growth in health spending.
- Give patients price and quality information to permit them to make informed decisions.
- Eliminate needless bureaucracy to create an efficient, streamlined, and coordinated system that minimizes red tape for patients, physicians, and other providers. Furthermore, health system reform must leave medical decision-making in the hands of physicians and their patients.

We believe that to enable physicians to best serve the interests of their patients, meaningful health system reform also must contain these elements:

- Significant antitrust relief that enables physicians to have a strong voice to balance the growing corporate and government domination of health care.
- Allow for physician-directed health care networks.
- Enhanced self-regulatory powers that would enable the profession to effectively police itself and its members without the threat of unwarranted litigation.

We also believe that major reforms in the professional liability system must be enacted, including a $250,000 cap on non-economic damages, limits on plaintiff attorneys' fees, and other measures that would minimize defensive medicine.

Every American will be affected by this legislation. The focus of policy-makers should be on how their decisions will affect patient care. Any system that raises significant barriers between patients and physicians will not provide the quality care our nation expects and deserves. We believe the above principles outline a framework for establishing constructive, effective, and needed health system reform.

Join your colleagues in your county and state medical societies and the AMA. And stand with the organizations that stand behind you.

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Vaginal Birth After Cesarean Section in a University Setting

Mureena A. Turnquest, MD; Tamara James, MD; Carolyn Marcell, RN; Joseph A. Spinnato, MD



Despite numerous reports in the literature almost universally endorsing the safety of a trial of labor after a prior cesarean section, it is used in only a small fraction of eligible patients. Our investigation, conducted at the University of Louisville, examines the safety of such a protocol. Two thousand seven hundred fifty-seven patients were delivered during one year; 282 had a history of at least one prior cesarean section. Of the 259 patients eligible, 218 (84%) underwent a trial of labor, and 168/218 (77%) were delivered vaginally. There were 6 cases of uterine dehiscence and 1 uterine rupture. No hysterectomies were performed. Maternal morbidity was significantly greater in the failed trial-of-labor group. There was one perinatal death that was unrelated to a trial of labor. A previous diagnosis of cephalopelvic disproportion or failure to progress did not preclude a trial of labor, and 69% of these patients delivered vaginally. Our data suggest that a trial of labor following one or more previous cesarean sections is a safe option in a carefully selected population.

Abdominal delivery by cesarean section is the most frequently performed major obstetrical operation in the United States.[1] Nationally, the cesarean section rate is approximately 25% and is projected to reach 34% by the year 2000, if the current trend continues.[2] Repeat cesarean section accounts for one third of these procedures and is the single most common indication for all cesarean sections performed.[3]

Repeat cesarean section became the trend in the early 20th century after Dr E. B. Craigin in an address to the New York Obstetrical Society stated that once a cesarean section always a cesarean.[4] This dictum was considered appropriate during Cragin's era when virtually all procedures were performed through a classical incision. Almost 70 years later, the National Institutes of Health Task Force on Cesarean Childbirth, in response to the rapid escalation in the cesarean section rate, concluded that vaginal delivery after cesarean section was a safe alternative in patients with a low transverse incision.[5] In 1982 the American College of Obstetricians and Gynecologists published its guidelines on vaginal birth after cesarean section, and the latest revision of those guidelines (1988) make the criteria even less stringent.[6] Despite a myriad of publications in the obstetrical literature regarding the safety of a trial of labor after a cesarean section, only about 9% of patients receive a trial of labor.[7]

The primary purpose of our study was to evaluate our experience with a trial of labor in patients who had one or more previous cesarean sections through a low transverse uterine incision.

From the Division of Maternal-Fetal Medicine, Department of Obstetrics and Gynecology, University of Louisville, Louisville, KY 40292.

Materials and Methods

The study was conducted at Humana Hospital University of Louisville. The obstetrical and neonatal records were reviewed using ICD-9 codes for all patients with a previous cesarean section. During a 1-year period from April 1, 1990, to April 1, 1991, there were 2757 deliveries; 282 patients had one or more previous cesarean sections. Twenty-three patients were excluded due to lack of pertinent information required for data analysis.

All subjects had received information about a trial of labor during prenatal visits or upon admission to labor and delivery. Patients were considered eligible for a trial of labor if their previous uterine incision was located in the lower uterine segment. Patients with more than one previous cesarean section, breech presentation, suspected macrosomia, or twin gestation with the presenting twin in the cephalic presentation were not excluded from a trial of labor. Excluded were patients with a previous classical incision, a low vertical incision with extension into the contractile portion of the myometrium, previous myomectomy with extension into the endometrial cavity, or a fetus lying in the transverse position. Patients who refused a trial of labor underwent elective cesarean section at term.

Continuous tococardiography was used in all patients; a fetal electrode and intrauterine pressure catheter were placed as clinically indicated. Amnioinfusion was used liberally in patients with meconium or variable fetal heart rate decelerations. Pitocin was used as necessary to stimulate labor. Epidural anesthesia was not withheld from patients.

Manual exploration of the previous scar was encouraged in all patients with successful vaginal delivery. For the purpose of this study, dehiscence is defined as separation of the old scar without disruption of the visceral peritoneum of the uterus, whereas rupture is complete or incomplete separation of the scar with communication between the uterine and peritoneal cavity. Three groups were compared for maternal and fetal outcome. Group I consists of those patients who had an elective, cesarean section; Group II, a success-

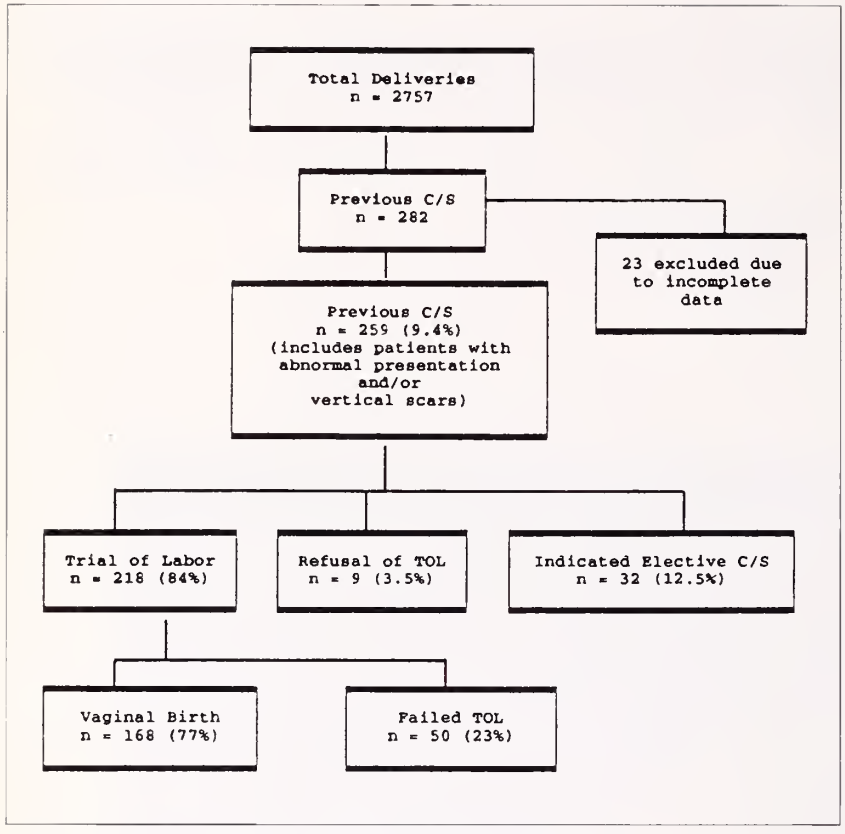


Fig 1 — Method of Delivery for Previous Cesarean Sections

ful trial of labor; and Group III, a failed trial of labor.

Data were analyzed using the χ^2 and the Fisher exact tests when appropriate as well as the Student's *t*-test.

Results

The study population consisted of 259 patients and their neonates. Two hundred twenty-seven were candidates for a trial of labor and 218 (84%) underwent a trial of labor. Of those, 168 (77%) had a successful vaginal delivery (Fig 1). An indicated cesarean section was performed in 32 patients (12%). Only 9 patients (4%) refused a trial of labor. Eight of 9 patients who refused had cephalopelvic disproportion or failure to progress with the previous pregnancy. Maternal demographics, such as age, gravidity, and parity, were similar in all three groups.

When analyzed by indication for primary cesarean section and subsequent successful vaginal birth, the rate ranged from 70% to 100%. In those individuals with nonrecurring causes, such as abnormal presentation or placental abnormalities, the success rate was higher (80% to 100%) than that of those with recurring causes, such as cephalopelvic disproportion or failure to progress (69%) (Table 1). The recurrence of cephalopelvic disproportion or failure to progress in a subsequent pregnancy was an infrequent event, representing only 16% of the population.

Oxytocin was used in 157 patients (72%) to either augment or induce labor. When comparing patients with spontaneous onset of labor to those who underwent induction of labor, there was no statistically significant difference in the success of vaginal birth (80% versus 67%); however, the latter group had a significantly longer active phase (8.4 ± 3.8 [SD] hours versus 6.8 ± 3.8, $p < 0.02$).

Suspected macrosomia did not preclude a trial of labor. There were 26 neonates with a birth weight greater than 4000 gm. Of these, 2 were delivered by elective cesarean section. The remaining 24 patients underwent a trial of labor; 14 (58%) were delivered vaginally. Shoulder dystocia was an infrequent complication. There appeared to be a trend toward an increased incidence of this complication in macrosomic infant (3/14) when compared to nonmacrosomic infants (2/154); however the numbers were too small for statistical evaluation.

Maternal morbidity and mortality of the three groups was compared. There were no maternal deaths during the study period. Group III had a higher maternal complication rate than either of the other groups. The most frequent complication was post partum hemorrhage (Table 2). All cases of post partum hemorrhage were controlled by medical management, and no hysterectomies were performed.

The overall incidence of uterine rupture was 0.5% (1/218), and dehiscence was 2.3% (5/218).

Table 1. Indications for previous cesarean section and outcome of subsequent trial of labor*

Indication	Vaginal Birth	%
CPD/FTP	62/90	69
Abnormal presentation	30/37	81
Fetal distress	55/67	82
Abruptio placenta	2/2	100
Placenta previa	3/3	100
Other	15/18	83

* CPD = cephalopelvic disproportion; FTP = failure to progress.

Table 2. Maternal camplicatians in previaus cesarean sectian*

	Graup I Elective C/S n = 41		Graup II Vaginal Delivery n = 168		Graup III Failed TOL n = 50	
	n	%	n	%	n	%
Hemarrhage	4	9.7	7	4.2	6**	12
Chariaamnianitis	0	0	12	1.7	4	8
Endametritis	2	4.9	3	1.8	4	8
Waund infectian	0	0	2	1.2	3	6
Other	1	2.4	10	5.9	3	6
Total	7	17***	34	20.2***	20	40***

* C/S = cesarean sectian; TOL = trial af labar.
** Patient with chariaamnianitis and hemarrhage is listed under hemarrhage.
*** $p < 0.01$ (ar $p = 0.0087$).

The failed trial-of-labor group had a higher number of defective scars (5/50 versus 0/168). The difference was statistically significant (Fisher exact test, P = .0001; 95% confidence intervals for differences in proportions = .055 and .184), although probably not a clinical difference. Table 3 presents the data on the individual cases of uterine scar dehiscence. The single case of uterine rupture was in a patient at 42 weeks' gestation with two prior low transverse scars. She developed severe pain in the upper abdomen during the second stage of labor. This was followed by repetitive severe variable decelerations in the fetus. Labor had been accomplished after 2½ days of induction by pitocin. An emergency cesarean section was performed with delivery of a 3750 gm male infant with an Apgar score of 2/3/3 at 1, 5, and 10 minutes respectively. The infant was hypoxic at birth, but a computerized axial tomography scan of the head and an electroencephalogram were unremarkable. Long term follow-up was not done on this infant.

There was no statistical difference in neonatal outcome when the three groups were compared (Table 4). One perinatal death occurred in Group II. The fetus was delivered at 31 weeks' gestation following intrauterine death prior to hospital admission.

Discussion

Clinicians seem to be reluctant to offer a trial of labor to patients with a prior low transverse scar due to their fear of uterine rupture and subsequent catastrophic maternal or fetal outcome. Our data illustrate that even in a university setting

Table 3. Patients with detected scar dehiscence*

Pt	GA (wks)	Prev scar	# af prev c/s	Made af del	Pit (min)	Apgar 1/5	Indic far this c/s	Mat Sx	FHT tracers	Dur af active labar (hrs)	BWT (g)	Management
1	41	LTCS	1	c/s	y	8/9	CPD	nane	narmal	6	4196	repair
2	42	LTCS	3	c/s	y	7/9	CPD	nane	severe variables	6	3544	repair
3	41	LTCS	1	c/s	y	8/9	CPD	nane	severe variables	6	3600	repair
4	38	LTCS	1	c/s	y	7/8	CPD	nane	severe variables	6	3572	repair
5	35	classical	1	elective	n	8/9	classical	nane	narmal	0	2523	repair
6	38	LTCS	1	c/s	y	9/9	CPD	pain	severe variables	7.5	3232	repair

* GA = gestatianal age; pit = pitacin; mat sx = maternal symptams; FHT = fetal heart tanes; BWT = birth weight; LTCS = law transverse cesarean sectian; c/s = cesarean sectian; CPD = cephalapelvic disprapartian.

Table 4. Outcome parameters in patients with previous cesarean section*

	Group I Elective C/S n = 41	Group II Vaginal Delivery n = 168	Group III Failed TOL n = 50
Apgar score at 5 min**	9	9 ± 1	8 ± 1
Birth Weight (g)**	3081 ± 651	3258 ± 630	3522 ± 682
Gestational age (wks)**	37.8 ± 2.8	38.9 ± 2.6	39.7 ± 2.1
Perinatal death	0	1***	0
Hysterectomy	—	—	—
Maternal death	—	—	—

* C/S = cesarean section; TOL = trial of labor.
** Mean ± SD.
*** Antepartum death.

with an indigent population a trial of labor after a cesarean section is a safe and reasonable alternative to elective, repeat cesarean section. Moreover, the patients were shown to be very accepting of a trial of labor when appropriately counseled; only 4% refused. Our overall vaginal delivery rate was 77% and is in line with that published by other investigators.[8-11]

The indication for previous cesarean had minimal bearing on the success of subsequent vaginal birth. Patients with a previous diagnosis of cephalopelvic disproportion or failure to progress had the lowest success rate for vaginal delivery. This rate, however, was not statistically different from that of patients with other indications for previous cesarean section; therefore, these patients should be encouraged to undergo a trial of labor. If this group were to be excluded from a trial of labor, 41% of the patients with a previous cesarean section who are considered candidates for a trial of labor would undergo an elective cesarean section.

There were no maternal deaths. To date, there has been no report of a maternal death directly related to uterine rupture from a previous low transverse uterine scar.[12] Catastrophic fetal outcome resulting in perinatal death has been reported;[13] it occurred when labor was not under direct physician supervision and without continuous fetal monitoring performed. The one perinatal death that occurred in the vaginally delivered group was unrelated to a trial of labor.

The concern about rupture of a uterine scar seems to be unwarranted; the incidence in our study was less than 1% and has been corroborated by numerous other investigators.[14-16] The incidence of dehiscence, however, occurred slightly more frequently, but in no instance was there neonatal or maternal compromise. Neither the number of previous scars nor the duration of active labor appeared to be related to scar dehiscence. There is no pathognomonic sign of uterine scar dehiscence; although in our series, an abnormality in the fetal heart tracing, possibly due to prolapse of the umbilical cord through the dehisced scar, seemed to be the most consistent finding. We were unable to determine if there was any significant association between oxytocin use and scar dehiscence, because most patients with scar separation received oxytocin at some time during the course of labor. Hence, we do not believe that oxytocin is contraindicated in this group of patients.

The patients in Group III were noted to have a higher rate of scar dehiscence. This difference is statistically significant, although probably not a clinical difference. In patients delivered abdominally after a trial of labor, a defective scar is readily noted at the time of laparotomy. In those who undergo vaginal delivery, however, palpation of a defective scar may be more difficult to ascertain, particularly when exploration of the lower uterine segment is carried out by a junior resident who may be unfamiliar with the consistency of a defective scar. In addition, although palpation of the lower uterine segment is encouraged, this information was inconsistently recorded in the delivery records. The necessity of palpation after delivery is controversial, because scars not actively bleeding do not require operative intervention. A subsequent trial of labor in patients in whom a defective scar is detected after a previous vaginal delivery, however, is not advised, although a randomized prospective study

testing this hypothesis has not been reported. Further studies perhaps will resolve this issue.

Data reported by Phelan et al[14] showed that a trial of labor in patients with a prior uterine scar was associated with a decreased risk of maternal morbidity when compared to those individuals who underwent elective, repeat cesarean. When stratified for febrile morbidity, however, an increased risk was found in the group with a failed trial of labor. The latter observation, also confirmed in our study, is not surprising. Even in the presence of an unscarred uterus, if a primary cesarean section is required after a trial of labor, patients have an increased risk of febrile morbidity when compared with patients undergoing an elective cesarean, especially when prophylactic antibiotics are not administered.[15]

Our study supports the premise that fetal macrosomia should not be a deterrent to a trial of labor. Most macrosomic infants were delivered vaginally. Furthermore, fetal macrosomia cannot be predicted reliably prior to delivery. Benacerraf et al[16] have reported a sensitivity of 65% for ultrasound diagnosis of fetal macrosomia.

In our retrospective study we have confirmed that a trial of labor after a previous cesarean section is an acceptable course of management that can be safely accomplished. Patients, however, should be chosen carefully, and intrapartum monitoring of mother and fetus is essential to avoid catastrophic outcome.[17] Cragin's dictum was the rule during his era; but today with the widespread use of the low transverse incision and more sophisticated technology for fetal monitoring, his adage is now obsolete. It has taken almost 70 years and a rapid escalation in our cesarean section rate to realize that this practice of once a cesarean section always a cesarean section should be reversed and become the exception rather than the rule.

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A Case of Fabry Disease (alpha-Galactosidase A Deficiency)

William C. Thornbury, Jr, RPh, MSIV; Phil Aaron, MD

Dr Aaron is affiliated with the Westlake Primary Care center in Columbia, KY. Mr Thornbury is a Registered Pharmacist and a fourth year medical student at the University of Louisville School of Medicine.

Fabry disease is a rare lipid storage disorder, often silent until adulthood. We report the case of a rural, primary care patient whose initial presentation was that of progressive weakness from anemia. The anemia was determined to be of renal origin, and led to a diagnosis of Fabry disease. Although less than 500 cases of this disease have been reported in the literature, such events remind the clinician that the environment of rural practice is not immune to unusual and diverse medical problems.

Fabry disease is a hereditary X-linked glycosphingolipidosis resulting from the defective enzyme, alpha-galactosidase A, a hydrolytic lysosomal enzyme. A lipidosis is a lipid storage disease. In Fabry disease, the defective enzyme allows incompletely metabolized lipids to accumulate in the lysosomes of individual cells throughout the visceral tissues and fluids of the body. This increased deposition of lipid is of particular importance within the cardiovascular, renal, and neural tissues, yielding the major clinical manifestations. Symptoms include debilitating pain and paresthesias, hypohidrosis, corneal opacities, proteinuria associated with renal impairment leading to hypertension and renal failure, cardiovascular and cerebrovascular ischemia and infarction, and the unusual telangiectatic skin lesion angiokeratoma corporis diffusum universale that is diagnostic. Patients, previously asymptomatic, may present in the third, fourth, or fifth decade of life with subtle renal or cardiac manifestations. Fabry disease is slowly progressive, but fatal — usually, as a result of the renal, cardiac, or cerebral complications due to the vascular derangement caused by the disease. The mean life expectancy is 41 years; however, patients may survive into the sixties.[1]

Case Report

A 41-year-old white male presented to a rural outpatient clinic with a complaint of weakness of 1 week duration, which had progressed to the point that he was unable to work. Upon inquiry he admitted to having a 2-year history of hypertension, general malaise for some months, a "flu-like" illness approximately 1½ months previously, and mild nose bleeds. Notable findings included: Pallor, guaiac positive stool, BP 200/120, RBC 1.00 X10e6 mm3, HGB 5.8 gm, HCT 18.3 vol%, B12 430, Folate 5.3, CO_2 15 and Serum Iron 176. He was admitted to the hospital with macrocytic anemia and hypertension. His contributory admission laboratories were: BUN 168 mg/dl, Serum Cr 26.0, LDH 513, K+ 7.1mEq/l, Ca+2 6.2, and Phos 12.8. An additional diagnosis of chronic renal failure was made and the patient was subsequently transferred to the renal service of a tertiary care facility.

Following a complete workup, the patient was found to have a Grade II/VI systolic ejection murmur, a +2 pitting edema about the ankles, and low grade fever. Bacterial cultures were negative and the WBC was not elevated. He was transfused with 4 units of packed red blood cells, hemodialyzed, and a peritoneal dialysis catheter installed. He was discharged on a high dose of ACE inhibitor, Alu-Cap, and ranitidine.

Over the next 3 months, he was treated for dehydration, gouty arthritis, and his oral antihypertensive medication was amended following continued elevated BPs. His reports of general weakness continued, more specifically described as "leg weakness." After 6 months, he was nearly bedridden by pedal edema and a newly progressive numbness that began in his great toe and ascended to his knees. He was again referred to the tertiary renal service for an assessment and neurologic consult.

It was upon this admission that the first dermal lesions were noted, described by the renal service as facial and sacral areas of erythema with hypertrophic skin changes. Left ventricle hypertrophy was also noted. The neurology service reported in their assessment that the numbness had

progressed to the patient's hands. A Dupuytren contracture of his right hand and muscle wasting of the thenar eminences were remarkable. His distal motor strength was poor, especially in the legs where he could not dorsi- or plantar flex against resistance. His ankle jerk reflex was absent bilaterally, and the left pedal pulse was absent. Severe sensory and motor polyneuropathy of uncertain origin was diagnosed — perhaps resulting from his end-stage renal disease, which itself was of undetermined etiology. A biopsy of the left gastrocnemius muscle and sural nerve yielded the pathologic report of severe nerve demyelinization and "Zebra body" inclusions within the smooth muscle of an artery, suggestive of Fabry disease.

Examination of leukocyte alpha-galactosidase activity by a lysosomal disease laboratory yielded a result of 3nmoles/mg protein/hr (normal mean: 85 ± 16). Two control enzymes were found to be within normal limits, and a conclusive diagnosis of Fabry disease was made.

Subsequent ophthalmologic examination demonstrated classic Fabry signs of corneal verticillata, tortuous conjunctival retinal vessels, and lens changes. His three daughters were also examined and appeared to be Fabry carriers.

Discussion

History and Genetics — Fabry disease was first identified in 1898 by two dermatologists, Anderson in England and Fabry in Germany.[2,3] Both physicians independently described the angiokeratoma lesion — a localized collection of dilated, thin-walled blood vessels covered by a cap of warty material.

The disease is an extremely rare X-linked recessive disorder with a prevalence estimated at 1:40,000 births, mostly Caucasian.[4] Usually, the disease is only fully expressed in hemizygous males. Most heterozygous females exhibit an attenuated form of the disease due to an intermediate level of enzyme activity; females often exhibit the symptom of corneal clouding. As with all X-linked disorders, a hemizygous (XY) father will produce **unaffected** male children (the affected father only providing the Y chromosome), and the female children will all be carriers of the gene. From a heterozygous (XX) female, an average of 50% of the male children will have the disease and an average of 50% of the female children will be carriers.

Biochemistry — The defective lysosomal enzyme, alpha-galactosidase A, leads to the accumulation of glycosphingolipids with terminal alpha-galactosyl moieties in the lysosomes. Glycosphingolipids are lipids containing sphingosine residues (sphingosine is a long-chain unsaturated amino-alcohol), a fatty acid bound to the amino group, and sugars bound to the alcohol group. The major lipid deposited is the trihexoside, galactosylgalactosylglucosylceramide. Studies by Kint in 1970 have localized the genetic disorder to the long arm region of the X chromosome.[5] There is more than one cause of malfunction of the enzyme. Several different molecular lesions have been identified on the chromosome including point mutations, duplications, deletions, and splice-junction defects. Thus, three categories of enzyme deficiency have been defined: (1) Patients with no enzyme protein and no enzymatic activity; (2) Patients with normal or decreased enzyme protein and no enzymatic activity; and (3) patients with enzymatic protein and enzymatic activity sufficient to hydrolyze substrate.

Pathology and Clinical Manifestation — In lipid storage diseases, deposits of incompletely digested lipid come from endogenous sources. In Fabry disease, the pattern of glycosphingolipid deposition occurs unlike that in any other lipidosis. Lipid metabolites may accumulate within avascular tissues such as neural cells and the cornea; or, metabolites may be transported throughout the body by LDL and HDL lipoprotein fractions, and, perhaps, endocytosed by vascular endothelial and smooth muscle cells.[4,6-8]

The characteristic pathology of Fabry disease involves diverse deposits of crystalline glycosphingolipids that show birefringence under plane-polarized light. At high resolution, a pattern of concentric or lamellar inclusions with alternating light- and dark-staining bands may be observed.[9] These lipid deposits are found in all areas of the body, but predominate in the endothelial and smooth-muscle cells of blood vessels, the epithelium of the cornea, muscle fibers of the heart, and in ganglion cells of the dorsal roots of the autonomic nervous system.

Telangiectic lesions, which may occur anywhere on the body including the oral mucosa, often appear in childhood or adolescence and vary in size up to several millimeters in diameter. The lesions are dark red to blue-black, may be slightly raised due to hyperkeratosis; these lesions blanch with pressure. Corneal opacities are ob-

servable in the female, with ocular lesions present in all eye elements. Sweating may be decreased due to autonomic involvement. Lancinating pain, the most troublesome symptom, has been reported to last from minutes to days. It has been described as an agonizing burning in the palms, soles, and proximal extremities that may increase in severity with age. Anginal pain, myocardial infarction, cardiomegaly, and congestive heart failure are secondary to the vascular abnormalities.

Renal involvement due to deposition of unmetabolized lipid includes the epithelial and endothelial cells of the glomerulus, Bowman's space, loop of Henle, and distal tubules. At the same time, deposition of lipid metabolites within the smooth muscle cells of the vascular system produces an increasing stenosis of the vascular lumen and leads to hypertension. Desquamated renal epithelial cells, red cells, casts, protein, and lipid globules can be found in the urine beginning in childhood or adolescence. The urinary lipids appear as Maltese crosses under plane-polarized light. Increased blood urea nitrogen levels occur later in the second, third, and fourth decade, followed by the renal failure of end-stage renal disease.

Other features of the disease include chronic bronchitis, lymphedema of the legs, diarrhea, osteoporosis, retarded growth, and delayed puberty.

Diagnosis — In males, the clinical diagnosis is made by a careful history, identification of the unique skin lesions, and observation of the corneal dystrophy. Clinical signs often appear within a concert of systemic problems characteristic of Fabry disease. These include renal failure, cerebral ischemia/stroke, or myocardial abnormalities. Before the appearance of skin lesions in childhood, recurrent fever associated with pain in the hands and feet is common. Symptomatology must be differentiated from rheumatic fever, a collagen vascular disease, erythromelalgia, or a neurosis. The angiokeratoma corporis diffusum universale is unique. However, it should not be confused with the angiokeratoma of Fordyce (appearing before age 30 and isolated to the scrotum); angiokeratoma circumscriptum or naeviformus (clinically resembling that of Fordyce); or, the angiokeratoma of Mibelli (warty lesions located on the extensor surface of young adults and associated with chilblains).[10-12] A slit lamp examination can identify the corneal dystrophy.

In female carriers, corneal opacity is the hallmark — found in about 70% of patients. About 30% of heterozygote females exhibit isolated skin lesions, which may be present on the trunk, breasts, back, and posterolateral thighs.[9]

In individuals with the clinical symptoms previously described, a diagnosis is confirmed by either deficient alpha-galactosidase A activity in cultured skin fibroblasts, plasma, leukocytes, or tears; observation of the accumulated product, globotriaosylceramide, in plasma or urinary sediment; or, positive histologic detection of lipid-laden cells biopsied from skin or tissues. More accurate diagnosis can be made by demonstration of a molecular lesion in the alpha-galactosidase A gene or by restriction fragment length polymorphism (RFLP) analysis.

Medical Management — The medical management of the patient with Fabry disease presently is relegated to the symptomatic control of neuronal, renal, pulmonary, and cardiac complications of the disease. The severe pain experienced by these patients (from an, as yet, undetermined pathophysiology) may be controlled with maintenance phenytoin and carbamazepine in combination, or corticosteroid therapy; however, a dose-dependent exacerbation of autonomic dysfunction has been reported with carbamazepine use.[13-15] Renal failure, the most common cause of death, may be managed with dialysis or by renal transplant from a non-Fabry donor. It is important to note that familial donors that are Fabry heterozygotes demonstrate a significant graft dysfunction 5 years post transplant; recurrence of the disease has also been reported in a successful renal allograft 11 years after surgery.[16, 17] In some allograft patients, biochemical and clinical regression, with relief of pain, has occurred.[14] This is believed to be because the transplanted kidney supplies the alpha-galactosidase A enzyme. Obstructive pulmonary disease has been defined in some patients; therefore, smoking should be discouraged. Hypertension, myocardial ischemia/infarction, and cerebral vascular disease are consequences requiring close observation and management. The angiokeratoma may be removed by argon laser for improved cosmetic appearance.

Fetal liver transplantation has been attempted in an effort to replace the deficient enzyme.[18] The long-term effectiveness of this has not been established. An attempt has been made to deplete the serum of substrate by plasmapheresis.[19] However, there is some question as to whether enough of the substrate can be depleted

in relation to the rate of accumulation of the product to benefit the pathologic tissues.

The most encouraging advance in the treatment of Fabry disease is enzyme replacement therapy. Preliminary reports of this form of treatment have been encouraging.[20,21] Clinical trials are underway.

Genetic Counseling — Families identified with Fabry genotypes should be advised to screen all suspect heterozygotes. Prenatal screening includes the demonstration of deficient alpha-galactosidase A activity and an XY karyotype, or by the demonstration of a specific alpha-galactosidase A mutation. This can be accomplished via chorionic villus sampling or amniocentesis.[22-26] Families with offspring affected by Fabry disease should receive vocational counseling, perhaps discouraging careers involving a high degree of manual dexterity, physical or mental exertion, or environments with large variations in temperature or humidity.[9]

Conclusion

The crisis of renal failure is a common presentation of patients in late-stage Fabry disease. In this case, the patient presented with complaint of general malaise which was found to be of anemic origin, his anemia of renal origin, and his renal failure of genetic origin.

Fabry disease is a very rare lipid storage disease. There have been fewer than 500 cases reported in the literature. In the undiagnosed patient, astute clinicians may observe a trilogy of angiokeratotic skin lesions, history of painful paresthesias and fevers, and ophthalmologic signs such as corneal opacities and conjunctival lesions. These observations are often made in the light of renal, cardiovascular or cerebral vascular pathologies as the most common complications.

In the management of Fabry disease today, perhaps the most effective therapy is genetic counseling which includes prenatal screening for at-risk families. Patients with Fabry disease are managed for crises of pain, and for vascular abnormalities such as control of hypertension and myocardial ischemia/infarction, end-stage renal disease, and cerebral vascular disease.

Fabry disease is usually fatal by the fourth decade; however, kidney transplantation has proven to be of benefit in some patients. Enzyme replacement therapy, as is presently available for patients with Gaucher disease, is the focus of current research. Clinical trials are ongoing.

ACKNOWLEDGMENTS: The authors wish to gratefully acknowledge the effort and contribution of Mary A. Hilton, PhD; Fritz Hilton, PhD; Richard Aud, MD; and Patricia Quinby, MD, in the preparation of this manuscript.

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Preparation — Manuscripts should be typewritten in double spacing throughout, including references, tables, legends, quotations, and acknowledgments. Submit the original and one copy, retaining a copy for proofreading. Ordinarily articles should not exceed 3,000 words in length. Titles should include the words most suitable for indexing the article, should stress the main point, and should be short. A synopsis-abstract must accompany each manuscript. The synopsis should be a factual (not descriptive) summary of the work and should state the problem considered, methods, results and conclusions.

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Neisseria Meningitidis Early Treatment and Complement Deficiency

Celestino Vega, MD; Patricia M. Quinby, MD

From the Department of Family and Community Medicine, University of Louisville, 530 S Jackson St, Louisville, KY 40292.

The purpose for this report is to demonstrate the importance of early treatment of patients with suspected bacterial meningitis, as well as the need to investigate complement deficiency in such patients.

This case report describes the diagnosis and treatment of a 20-year-old woman with *Neisseria meningitidis*. She had a past medical history of streptococcal meningitis at 2 weeks of age and was found to have a complement C_6 deficiency.

Case Report

A 20-year-old mentally retarded black woman was accompanied by her mother to the emergency room at 2 AM because of a 2-day history of headache and a 1-day history of lower abdominal discomfort with no fever or chills and no change in activity. Her past medical history was significant for streptococcal meningitis at 2 weeks of age (the cause of her mental retardation). The patient was on no medications and had no known drug allergies. She lived with her mother and younger brother and sister, and had a negative history of alcohol, tobacco, or drug use. She attended high school in a special education program.

Initial examination of the patient showed her to be in no acute distress with a temperature of 103°F. On physical exam, the neck was supple, without adenopathy, tenderness, or rigidity. She had mild tenderness to trapezius muscles on palpation. No rashes were noted. Results of the throat examination were within normal limits. A neurological exam was unremarkable. Examination of the patient's abdomen found it to be soft, with mild suprapubic tenderness. Bowel sounds were normoactive and no organomegaly or masses were noted. The findings of the remainder of the exam were within normal limits (Table 1).

Our impression at the time of the visit to the emergency room was that the patient had meningitis. She was admitted to the hospital and started on IV Cefotaxime. We chose to treat her with Cefotaxime (a third generation cephalosporin) because of its wide range of activity against common meningeal pathogens and excellent penetration into the cerebrospinal fluid.

By day 2 of hospitalization, the patient was completely asymptomatic and afebrile with no headaches or abdominal complaint. Laboratory results on that day showed urinalysis to be within normal limits; Chem 7 to be within normal limits; CT scan of the head with contrast was within normal limits; urine, blood, and CSF cultures were all negative to date. CBC with differential showed: 35.6 white blood cells with 73% segs, 19% bands, 3% lymphocytes, and 5% monocytes. On the afternoon of hospital day 3, blood cultures had grown gram negative diplococci (*N meningitidis*) (beta lactamase negative — ACYW135). The patient was afebrile and asymptomatic at the time. The patient was started on intravenous penicillin G for a 7-day course. Further study showed the patient to have deficiency of complement C_6 at 1.7 mg/dl (normal range 4.8-7.2). Complement C_3, C_4, C_7 and C_8 were within normal limits. IGM, IGE,

Table 1. Initial Labaratary Findings

Test	Results
Urinalysis	→ Within Normal Limits
Chem 7	→ Within Normal Limits
Rapid Strep Screen	→ Negative
Pregnancy Test	→ Negative
Chest X-Ray	→ Within Narmal Limits
Plain CT of Head	→ Within Narmal Limits
CBC with Differential	→ WBC-24.3
	Bands-40
	SEGS-41
CSF	→ RBC-4
	WBC-14
	Pratein-85
	Glucase-82
	Palys-77%
	Lymph-17%
	Monos-6%

IGD, IGA, and IGG were also within normal limits. The health department was contacted and the patient's immediate family was started on Rifampin prophylaxis. On the morning of the 7th hospital day, the patient was discharged home with normal white count. She was completely asymptomatic and afebrile.

Comment

In patients with suspected bacterial meningitis, treatment should be initiated without delay while awaiting results of cultures from CSF.[1-4] The drug of choice should be third generation cephalosporins.[3-8]

Further studies should be obtained in these patients in regards to complement system (especially terminal components) for the purpose of identifying patients at risk for recurrent *N meningitidis* infections.[9-11]

Complement deficiency states may have infectious consequences in certain patients due to inherited factors and ethnic backgrounds.[1, 2, 5, 9, 11, 12] As in the case of our patient, a C_6 deficiency has been shown to be prevalent among blacks, whereas among other populations such as the Japanese, a C_9 deficiency is common.[13] Screening tests for these inherited conditions may be helpful in individuals with recurrent bacterial infections.[12] The frequency of complement deficiency states seen in patients with systemic meningococcal infections ranges between 0% and 50%.[14]

Individual component deficiency states can be grouped into four categories according to the portion of the complement cascade affected by the defect. The complement cascade is composed of numerous activations of complex enzymes converging at a level to form a common terminal pathway. The four categories are additionally split into early and late components and classical and alternative pathways. Inheritance of components of the two pathways behave as autosomal recessive traits.[12-14]

Our patient had a C_6 complement deficiency which is considered a late complement component. The association of meningococcal disease with late component deficiency is striking, both in terms of the frequency of infection (50% to 60%) and the frequency with which these deficiencies occur in individuals with meningococcal disease.[13] It is common for the initial episode of meningococcal disease to occur at a median age of 17 years in patients with later complement deficiencies. This is in contrast to a median age of 3 years in the general population, and about half of these individuals will have recurrent infections. Patients with this type of late complement component deficiency do not have bactericidal activity in their serum, thereby increasing their risk of infection.[11, 14]

Evidence supports the role for the complement system in the prevention of meningococcal disease. Seventy-five percent to 85% of all systemic bacterial infections seen in individuals with complement deficiency are caused by meningococci. Direct correlation between core complement activation and bactericidal activity in the case of meningococcal infection involves the end result of multiple organ system failure, septic shock, and death. It has also been shown in addition to the high frequency of infection in recurrent disease that a relapse rate of meningococcal disease less than 1 month after a prior infection is approximately 10 fold greater than in normal individuals. Uncommon meningococcal serum groups also appear in complement deficient individuals. Prior disease does not dramatically reduce the subsequent risk of meningococcal infection.[13]

Since deficiencies of specific components of the terminal complement system are known to be inherited, we feel strongly that identification and documentation of these patients should be pursued.[9, 11, 14] Identification is important because these patients are at a greater risk of developing bacterial infections, and preventive action can be taken to decrease the risk of recurrent infections.

A question still exists whether to treat these patients with prophylactic antibiotic such as monthly injections with Bicillin and/or vaccinating with *tetravalent meningococcal capsular polysaccharide*.[5, 10, 11, 13] It is our opinion that patients with recurrent bacterial infection should receive both monthly antibiotic injection and the vaccination. In the case of this patient, she has not had recurrent infections; however, it was decided to vaccinate her with Menomune-A/C/Y/W-135-single dose (*tetravalent meningococcal capsular polysaccharide*) as well as PNU-IMUNE®23 (Pneumococcal Vaccine, Polyvalent) as a prophylactic measure to avoid further episodes of meningococcal meningitis and pneumococcal disease.

ACKNOWLEDGMENTS: Thanks are extended to Anna Huang, MD, in the Department of Infectious Disease at the University of Louisville, for advice and suggestions.

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Thoughts on the Natural History of Life

"While the issues revolving around the concept of assisted suicide are far from resolved, perhaps there is inherent in their discussion the opportunity to reacquaint ourselves with the course and the outcomes of the illnesses we treat apart from the interventions we have at our disposal."

The recent trial of Dr Kevorkian in Michigan has raised several issues of concern to all of us in the medical community and society at large: dignity in dying, the alleviation of suffering and fear, the society's genuine interest in the protection of individual freedoms and life, and the physician's role in all of these issues. Yet, one issue which is of particular interest to physicians and a treasured part of our heritage has largely been omitted from the popular descriptions of this debate. That issue is the understanding of the natural history of illness.

At the core of this issue is the understanding that the natural history of life as we know it is death. In an era of medicine in which physicians had little to offer the patient with regard to the cure or reversal of disease processes, we and our patients had a keen understanding of the natural history of many illnesses as a result of many painful and humbling observations of diseases and their outcomes. From these observations came a growing database of the hallmarks of individual diseases, the passion to seek and find methods to alter their courses, and ultimately the devices of intervention. As our armamentarium grew and our ability to intervene became more sophisticated, we have at times been able to alter the natural history of certain illnesses to the point of insuring their extinction. At other times we have delayed or prevented complications of diseases and, in the process, provided a tremendous enhancement in the quality of life of our patients. Yet, many diseases remain beyond cure and, as in the case of AIDS, new illnesses continuously arise to challenge us.

Perhaps as a result of our success we have become ingrained with a fear of acknowledging the natural history of life and, in so doing, have inadvertently created in the eyes of our patients the impression that no disease is to be tolerated and that acceptance of or, as in the Michigan case, facilitation of the disease's outcome is less than optimal. While the issues revolving around the concept of assisted suicide are far from resolved, perhaps there is inherent in their discussion the opportunity to reacquaint ourselves with the course and the outcomes of the illnesses we treat apart from the interventions we have at our disposal. In so doing, we may find ourselves once again encountering new understanding and appreciation for the diseases that affect our patients and new passion for making their lives better.

Daniel W. Varga, MD



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One Choice/One Voice

The focus of the medical community continues to be on health system reform and how it will affect health care, the medical profession, and our families. We need to be alert to ways we can be involved in making sure that health system reform is done right.

All physicians and physician spouses need to register to vote, and exercise that right at every opportunity. Electing the right candidate is vital to our communities, state, and nation. We must be involved in this process.

Our Alliance members will be asked to focus on four simple words: "ONE CHOICE/ONE VOICE." We need to promote "UNITY, COMMITMENT, INVOLVEMENT." Our voice must be as one by letting all physician spouses across the state know that when they make the choice of membership, they make a mighty force to speak on the issues that will shape our future. This is a golden opportunity for the medical community, a chance for us to speak with one voice on behalf of all patients and physicians.

If we are to promote our "ONE CHOICE/ONE VOICE" emphasis effectively, we must reach out to all physicians' spouses, one-to-one, to say "PLEASE JOIN US." We need you and you need us. We cannot depend soley on our membership committees to recruit our new members, and renew our former members.

Physicians must encourage their spouse to join. Give your spouse a membership "GIFT CERTIFICATE" for an anniversary or birthday, or because you care.

This past year we were able to increase our members-at-large membership, but it is still not what it should be. We have many potential members residing in counties that do not have an organized Alliance. These potential spouse members are very vital to our organization and we want them as members. If you are one of these potential members, or if you know of someone, please encourage them to join.

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June 12-15, our Alliance will be represented at the AMA Alliance convention in Chicago by the following members:

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Joyce Clark (Mrs Danny)
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Debbie Bruenderman (Mrs David)
Betty Housman (Mrs Lloyd)



Joyce Clark

We are looking forward to representing our membership at the national convention.

Joyce Clark

KMA Alliance President

FOR MEMBERSHIP TO THE KMA ALLIANCE, FILL OUT THE INFORMATION BELOW AND SEND TO: KMA HEADQUARTERS, JEAN WAYNE, 301 NORTH HURSTBOURNE PKWY, SUITE 200, LOUISVILLE, KY 40222-8512.

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Roots

TO THE EDITOR: It was a busy Sunday. I was taking calls and making rounds for myself and five other doctors. I didn't have the luxury for chitchat. I walked into a hospital room and met Mrs Dorzback for the first time. She was the concerned wife of a man who was dying. I introduced myself as "Dr Hilb" who was covering for her husband's regular doctor. I performed a cursory examination and was planning to move along to the next patient on my long list after making a few superficial remarks.

Mrs Dorzback detained me and asked me where my family came from. She caught me off guard. I had only the vaguest recollection of my ancestry, but replied that the Hilbs came from Germany. "Oh yes," she said, "I think I know your family."

Upon my eventual return home that night I found some old papers my father had given me that made reference to some of his relatives. The next morning I dropped them off at the hospital room and went on to my office. Shortly thereafter, I received a call from Mrs Dorzback that she was prepared to tell me about my family.

Shortly thereafter, her husband died, and I did not want to be a bother. I became distracted by my usual medical routine and several weeks went by before we reestablished contact. I gave her a call and arranged to go to her house, along with my wife and father, to see what she had to tell me.

Part of my motivation was the simple courtesy of being respectful during her time of grief, since I sensed she would be disappointed if I did not share her enthusiasm for what she wanted to discuss. Was I thrilled when she escorted us into a little home office and proceeded to narrate the details of my family that I never knew. It seems one of her interests has been to develop an entire genealogical library of her family and the people of towns where her family originated. All at once she pulled out papers, pictures, and books which had all the intimate details of the Hilb family that went back a hundred years. Places of which I had never heard — Ulm, Haigerloch, Esslingen — all took on a meaning rather than just being some obscure points on a map of Germany. I had been taken back to another time and to another place.

Somehow I feel there is a connection from every human being to another. An elderly Jewish lady born in Germany links up with an American Jew 30 years younger with no previous contact or even the awareness of each other's existence. How did it happen that on a busy weekend on call when looking after another doctor's patient that I happened to meet Mrs Dorzback? Was it just a random event of chance? Or was it something more cosmic or spiritual? Life is full of surprises.

Jeffrey A. Hilb, MD
2256 Medical Arts Bldg
1169 Eastern Parkway
Louisville, KY 40217

Chest Pain

TO THE EDITOR: I have read the recent guidelines published in the *Lexington Herald Leader* of Wednesday, March 16, 1994, for treatment of chest pain.

As a result of these guidelines, will it be likely that any patient whose chest pain fails to respond to treatment with the most simple measures will have to be air lifted out of our rural hospital?

By way of contrast, I understand that a different philosophy of care as regards these patients exists in the British Health Service: In many cases, particularly if the individual is elderly, these individuals will be observed, taking aspirin and nitrates, possibly told to stay home until morning. About 90% will survive this "stress test"; about 10% will die. . . . Does our system, where tens of thousands of dollars will be spent on each of these individuals, serve society better? Especially when we consider that Britain, by every statistical standard, does as well mortality-wise as we do with the expenditure of far less money?

Personally, I believe that the number of days that a person lives is not the best indicator of the quality of their medical care. Doctors must consider the ability of the patient to function in society and their ability to respond to future treatment. If we fail to do this we will destroy the legal and financial structure of our society.

I am not advocating euthanasia — I am advocating that extensive treatment protocols be reserved for those who will benefit from them. No physician should ever spare his or her own personal effort in any manner in the care of any patient; however, it is quite another however to commit substantial social resources which are necessary to pay for elaborate transportation systems, hospitals, angioplasty suites, and so forth.

We always come back to the same point: A variety of statistics for life expectancy and mortality for a variety of conditions do not differ that greatly between England and the United States, and yet we spend an inordinately greater amount of money in the United States for this care than is spent in England. At one point it was thought that a national health system, as advocated by Clinton, would be a vehicle to achieve a sensible middle ground between the American and English extremes; judging on the basis of these

guidelines, what we will actually receive is rigid bureaucratic blueprints. Doctors who will administer them in a system of finite resources are going to find themselves the scapegoat.

F. Andrew Morfesis, MD

CAGE

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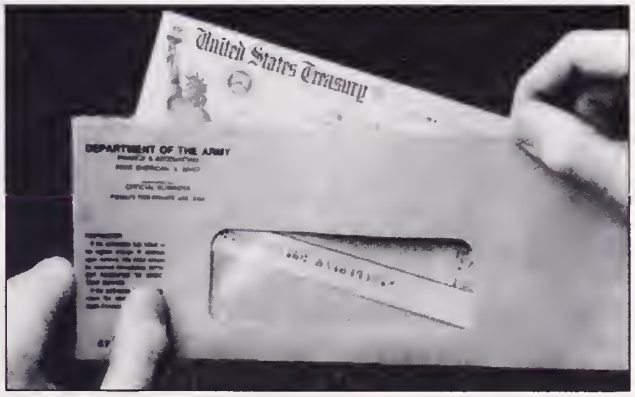
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KMA Board of Trustees Spring Meeting

The KMA Board of Trustees held its two-day Spring meeting on April 13 and 14, 1994, at the Holiday Inn Hurstbourne in Louisville. The Board members heard reports from the President; Secretary-Treasurer; Alliance President; Chair, KMIC Board of Directors; Director, Medicare Part B Program; and Commissioner, Bureau for Health Services. Representatives of the Board of Medical Licensure and University of Louisville School of Medicine also made reports.

Comprehensive reports were given concerning the activities of the Committees on National and State Legislative Activities. The Board spent considerable time discussing results of the 1994 Kentucky General Assembly, with emphasis on health care reform. The Board members endorsed the action of the Executive Committee to petition for a rehearing on KMA's lawsuit challenging the constitutionality of the recently imposed provider tax, and authorized use of the Legal Trust Fund for expenses attendant to the suit.

Endorsement was given to the Committee on Public Education's plans to publish a quarterly patient newsletter, develop a speakers bureau and slide program, and increase media communication. The recommendation of the Physician Organization Study Committee was also accepted that KMA provide information to members on managed care, through the resources of existing staff personnel and legal counsel.

Reports of the Membership Committee and the Ad Hoc Committee on the KMA/KMIC Headquarters Location were also accepted, and the Board approved plans of the Subcommittee on Domestic Violence to develop a seminar on domestic abuse. The Board members officially endorsed the concept of a Kentucky Center for Health Education, and accepted the Executive Committee's report to implement a revised format for the 1996 Annual Meeting on a trial basis.

The Board adopted a budget for the 1994-95 Association year; appointed William H. Mitchell, MD, Richmond, as PRO Advisory Committee Chair; and selected Salem M. George, MD, Lebanon, to replace Nelson B. Rue, MD, on the Kentucky Health Care Access Foundation Board of Directors. Names were finalized for appointment to the KMIC Board of Directors, and nominees were selected for service on Governor-appointed councils and boards.

The next regular meeting of the Board was scheduled for August 10-11, 1994. KMA

PEOPLE

Retired KMA member, **Martin Z. Kaplan, MD,** recently made headlines in the *Sarasota Herald-Tribune* for his heroic efforts in rescuing two fishermen caught in a Gulf of Mexico riptide. According to the newspaper, Dr Kaplan was sitting on Siesta Key Beach near his home at Peppertree Bay Condominiums when the incident occurred. The 76-year-old veteran swimmer leaped into the water, swam more than 150 yards, and helped the two fishermen make it to shore. A Boston nurse also helped in the rescue effort by swimming into the Gulf with a small inflatable tube.

The story reported that Dr Kaplan helped one fisherman latch onto the tube, which he rode to shore with the help of the nurse. Dr Kaplan then helped the other man swim piggyback until he reached the tube.

The news report explained that riptides, or rip currents, form when water hitting the beach flows back to sea through a thin spot in an offshore sandbar. Nationwide, they account for about 85% of all lifeguard rescues on open water, according to the US Lifesaving Association.

When the current took the men by surprise, they drifted away from the shore without realizing it.

Dr Kaplan moved to Sarasota upon retiring from pediatric practice in July 1987. During a distinguished career, he established the Diagnostic Clinic for the Mentally Retarded at U of L and developed the Sheltered Workshop.

Continuing in service to others, Dr Kaplan did not bask in personal recognition of his heroic act, but took advantage of the opportunity provided by media coverage to educate the public regarding how to handle riptides.



KMA President Ardis D. Hoven, MD, is pictured with Lonnie R. Bristow, MD, Chair, AMA Board of Trustees, at the 1994 National Leadership Conference State Growth Awards ceremony. Dr Hoven accepted an award on behalf of the Kentucky Medical Association for Extending the AMA Membership For The Third Consecutive Prior Year.

Albert B. Hoskins, MD, a Louisville internist and an assistant clinical professor of medicine at the University of Louisville, has been installed as governor for the Kentucky Chapter of the American College of Physicians.

Elizabeth Garcia-Gray, MD, has been named Chief of Staff of Ten Broeck Hospital for 1994. Other medical staff officers named are **Ronald Spears, MD,** Vice Chief of Staff; **Pran Ravani, MD,** Secretary; and **Clovis Crabtree, MD,** Treasurer.

UPDATES

Payments Received From HMOs

The following letter is from the Revenue Cabinet to health care providers regarding the exemption of Kentucky HMOs from the provider tax on premiums received:

TO: Health Care Providers

DATE: April 25, 1994

SUBJECT: Payments Received From Health Maintenance Organizations

Effective April 1, 1994, gross revenues from health care items or services must include payments received from health maintenance organizations (HMOs). Therefore, health care providers can no longer exclude HMO payments from "gross revenues" subject to the provider tax.

This change is a result of the decision rendered in *Health Maintenance Organization Association of Kentucky, Inc, et al, v Commonwealth of Kentucky, Revenue Cabinet, et al*, Franklin Circuit Court, Division I, Case No 93-CI-01275. The court ruled that HMOs are *not* subject to the Health Care Provider Tax on premiums received.

Also, the instructions for the Kentucky Health Care Provider Tax Return have been changed to reflect the court decision. The instructions will be mailed with the April 1994 return.

For additional information, please call the Revenue Cabinet at (502) 564-6823.

John W. Culbertson, Supervisor
Health Care Provider Tax
1266 Louisville Road, Station #59
Frankfort, KY 40620

Establish Practice Grant Program

In an ongoing attempt to address the maldistribution of physicians in Kentucky, the Rural Kentucky Medical Scholarship Fund, Inc offers an additional incentive for physicians who locate in critical areas — the Establish Practice Grant Program (EPGP). This program enables primary care physicians beginning a practice in a critical area of Kentucky with medical school educational debt to receive some assistance in repayment of their loans.

The EPGP offers $10,000 per year up to 4 years to a licensed full-time physician who will be locating in a critical county of Kentucky, as designated by the RKMSF. The EPGP is limited to five participants per year. The program currently has four vacancies for 1994.

If you are interested in additional information or an application, please contact the Rural Kentucky Medical Scholarship Fund, Inc/EPGP Office at 502/426-6200, or write to 301 N Hurstbourne Pkwy, Suite 200, Louisville, Kentucky 40222.

Consortium May Bring HIV Drug Tests

U of L is joining forces with the University of Kentucky, Lexington Clinic, Lexington Central Baptist Hospital, and private practices in Louisville and Bowling Green to bring clinical trials of investigational HIV drugs to Kentucky.

Doctors from U of L and UK announced March 8 the forming of the Kentucky Consortium for AIDS Research. The consortium, which will be based at UK, will present a patient base large enough to compete for large pharmaceutical grants.

The consortium will seek grants from drug companies, the National Institutes of Health, and the American Foundation for AIDS Research, a private foundation.

Anna K. Huang, MD, assistant professor of medicine in infectious diseases and head of U of L's participation in the consortium, said the new effort will benefit the university and the 300-400 HIV patients treated at U of L and affiliated hospitals.

"It will mean the ability to offer advanced, cutting-edge therapy for our HIV patients," she said. "They won't have to travel to other centers to get experimental therapy. It also will mean greater resources to allow us to better track the HIV population and epidemic in the area."

U of L's participation will be coordinated by the Division of Infectious Diseases.

Information from U of L and the other sites will be sent to Lexington, where UK will act as a data collection point. However, patients should be able to receive treatment at facilities in their area.

"It's really phenomenal to be able to do this for our patients," Dr Huang said. Those patients currently travel to Indianapolis, Cincinnati, Nashville, or other sites for treatment.

The consortium will have an immediate impact in the state. Dr Huang said Kentucky now has access to "a couple of studies" in the next few months.

One study the consortium members are trying to join involves a new drug which researchers think may be as effective as AZT, currently the front-line treatment for HIV. If effective, the new drug could be used as a substitute for patients who can't tolerate the side effects associated with AZT or could be used in combination with AZT to offer an even better treatment.

Kosair Charities Donation Caps U of L Drive for $5 Million Pediatric Building

The University of Louisville has announced receipt of the final funding needed to proceed with its plans to relocate its Child Evaluation Center and to establish a consolidated site for Department of Pediatrics offices.

A 2-year, $1.5 million grant approved by Kosair Charities Inc will enable U of L to build a new pediatric facility at the corner of Floyd and Chestnut streets near the Kosair Children's Hospital. The building will be named the Kosair Charities Pediatric Center pending final approval of the university. Construction should begin in early summer.

The 48,788-square-foot building will be connected to the exiting "K" Building of the U of L School of Medicine and will house both the

Child Evaluation Center and the faculty offices of the Department of Pediatrics. Planning is under way to connect Kosair Children's Hospital to the new facility.

The Child Evaluation Center diagnoses and treats children with developmental disabilities and genetic disorders. Since its establishment 27 years ago, the center has occupied several locations, including space in the old Louisville General Hospital, trailers directly behind the hospital, and its current location in the United Way Building at 334 E Broadway.

Additional funding for the construction of the building came from a $2.5 million grant from Alliant Health System Inc, for which the floors housing the pediatrics faculty offices will be named. The Child Evaluation Center will occupy the first two floors, which will be named for Dorothy K. Brecher in recognition of her $1.1 million bequest.

Kosair Charities, the charitable arm of the Kosair Shrine Temple, has been providing medical care for needy children in Kentucky and Southern Indiana since 1923.

Death Certificate Signing Laws

The Vital Statistics Branch of the Cabinet for Human Resources has requested that KMA inform physicians in Kentucky that requirements for completing and signing death certificates are spelled out by law. KRS 213.076 provides that the funeral director shall present the certificate to the medical certifier responsible for the patient's care within 5 days of death. The medical certification shall be completed, signed, and returned to the funeral director within 5 working days of its receipt. The Office of Vital Statistics is offering assistance for physicians in an attempt to improve signing times. Field representatives are available to provide training to staff on a one-on-one basis, or group, as requested. Questions regarding time





Representatives of state medical societies and AMA leaders stood united in support of health system reform principles during the AMA's March 8 summit in Washington, DC. KMA President-Elect Robert R. Goodin, MD, is pictured with US Senator Wendell Ford and Mrs Ford, top photo, and 1st District Congressman Tom Barlow and Mrs Barlow (bottom photo).

frames and laws governing who signs the death certificate may be addressed to Vital Statistics by calling 502/564-4212.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Daviess

Benjamin D. Keeley, MD — FP
P O Box 1370, Owensboro 42302
1990, U of Louisville

Hopkins

Justin B. Sedlak, MD — PTH
200 Clinic Dr, Madisonville 42431
1980, U of Alabama

Jefferson

Alexandra Gerassimides, MD — PTH
7410 Woodhill Valley Rd, Louisville 40241
1984, U of Louisville

Karyn Watters Granger, MD — FP
703 S 31st St, Louisville 40211
1990, U of Kentucky

Fawzi J. Hattab, MD — P
4107 Sylvan Dr, Floyds Knobs, IN 47119
1968, Baghdad U, Mosul

Bruce E. Prum, Jr, MD — OPH
6400 Dutchmans Pky #125, Louisville 40205
1988, Dartmouth

James E. Russell, DMD — DENT
225 Abraham Flexner #302, Louisville 40202

Seth D. Strichartz, MD —S
4001 Kresge Way #210, Louisville 40207
1984, UCLA

Shelby

John M. Rahe, MD — PD
171 Kentucky St #3, Shelbyville 40065
1989, U of Cincinnati

Warren

Steven K. Daugherty, MD — ID
1644 Cameron Way, Bowling Green 42103
1987, U of Missouri

Asad Fraser, MD — RHU
201 Park St, Bowling Green 42102
1983, Allama Iqbal Medical College

In-Training

Jefferson

Felicia A. Canada, MD — FP
Dimosthenis Dafnis, MD — N
Joseph B. Kwakye, MD — IM

Northern Kentucky

Peter Kai Wong, MD — FP

DEATHS

Elmo K. Hughes, MD
Louisville
1918-1994

Elmo K. Hughes, MD, a retired family practitioner, died April 13, 1994. A 1951 graduate of the University of Louisville School of Medicine, Dr Hughes was a life member of KMA.

Alfred A. Jacobs, MD
Edgewood
1929-1994

Alfred A. Jacobs, MD, an obstetrician/gynecologist, died April 16, 1994. Dr Jacobs was a 1957 graduate of the University of Louisville School of Medicine and a life member of KMA.

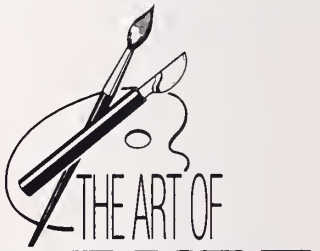
Stephen W. Jennings, MD
Covington
1949-1994

Stephen W. Jennings, MD, a family practitioner, died April 18, 1994. A 1978 graduate of the University of Kentucky College of Medicine, Dr Jennings was an active member of KMA.

Luther M. Wilson, MD
Bowling Green
1922-1994

Luther M. Wilson, MD, a retired general practitioner, died April 19, 1994. Dr Wilson was a 1946 graduate of the University of Louisville School of Medicine and a life member of KMA.

Mark your calendar today!



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September 20-22

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   Professional title _____

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6. Indicate sources of assistance provided to you in connection with this exhibit _____

7. Has this exhibit been displayed before? If so, when & where? _____

   _____

8. It is required that you attach a rough sketch or photograph and a brief outline of your exhibit to include: (a) content of the presentation and (b) the method, eg, equipment to be used.

Date _____ _____

Signature of Applicant

Fill out and mail to:
RICHARD A. KIELAR, MD, Chairman
Scientific Exhibits Committee
Kentucky Medical Association
301 N Hurstbourne Pky, Ste 200
Louisville, KY 40222

The Kentucky Medical Association welcomes and supports scientific exhibits as a facet of continuing postgraduate education.

Applications for space should be received before June 15, 1994.

- **COMMERCIALISM, such as utilizing the name of sponsoring organization or facility, either on the exhibit or in printed materials, is PROHIBITED.**
- **KMA provides, without cost to the exhibitor, one 2 ft. table, bracket lights and a title sign.**
- **Spotlights, view boxes, furniture, decorations, etc, may be furnished by the exhibitor or may be rented, if desired, by applying directly to the George E. Fern Company, 3752 Crittenden Dr, Louisville, Kentucky 40209.**
- **Transportation and erection costs are the responsibility of the exhibitor.**
- **Exhibit must be attended during intermissions to answer physicians' questions. It is also desirable to have someone in attendance throughout the program.**
- **Equipment which will create noise must not be used during the general sessions and, at other times, must be controlled by head or earphones or a muffling device.**
- **Exhibit must be dismantled and removed by 4:00 PM, Thursday, September 22, 1994.**
- **Exhibit space is strictly limited to footage and space allotted. No exhibit may extend into the aisle.**

Commonwealth Convention Center and the Kentucky Medical Association or its agents cannot guarantee against loss or damage and will assume no liability for damages nor guarantee the exhibitor against loss of any kind. The exhibitor agrees, with the Association, to be responsible to the Commonwealth Convention Center for damages that may occur as a result of the exhibitor's use of the facility.

AWARDS NOMINATIONS

The KMA Awards Committee is accepting nominations for the two highest awards the Association presents. The Distinguished Service Award is presented annually to a member of the Association based on the following criteria:

- Contributions to organized medicine (including membership in county society, attendance of county and state meetings, service on committees, leadership as an officer, etc.)
- Individual medical service
- Community health, education and civic betterment
- Medical research

The nominee may qualify on any one or all combinations of these points. Reasons for the nominations should be clearly stated.

The Kentucky Medical Association Award is presented to an outstanding lay person in Kentucky each year in honor of his or her outstanding accomplishments in the field of public health and/or medical care.

The Awards Committee will have the responsibility to choose recipients of the KMA Distinguished Service Award and the Kentucky Medical Association Award. Any county society or individual member may suggest nominees to the committee.

The awards are presented at the President's Luncheon during the annual meeting.

AWARD NOMINATION FORM

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☐ Distinguished Service Award (Physician)

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Honors and Awards: _____

(Describe nominees qualifications and other pertinent information which the Awards Committee may consider in making its decision.

Name of Person or Group Submitting Nomination: _____

Address: _____

Phone: (Home) _____

(Office) _____

Please fill in and mail to: KMA, Attn: Awards Committee, 301 N Hurstbourne Pky, Ste 200, Louisville, KY 40222

Deadline for receiving nominations is July 15.

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***COVER:** Join us in Louisville Sept 19-22 for this yeor's KMA Annuol Meeting.*

This issue contoins o short, informotive orticle on this progressive city ond how it will enhonce your ottendonce ot the Annuol Meeting. See poge 257.

Cover design ond photogrophy by Lee Wode of Louisville.

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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Second-class postage paid at Louisville, KY and additional offices. Yearly subscription rates: $25 domestic; $30 foreign. Single issues $3 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association,* 301 N Hurstbourne Pkwy, Suite 200, Louisville, KY 40222-8512. EDITORIAL AND ADVERTISING: Telephone 502/426-6200.

Listed in Index Medicus. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

National advertising representative: State Medical Journal Advertising Bureau, Inc, 11437 W 106th St, Overland Park, KS 66214, phone 800/788-2360.

The *Journal,* its editors, and the Kentucky Medical Association do not assume responsibility for the opinions and statements of its contributors and advertisers. The *Journal* reserves the right to make the final decision on all content and advertisements.

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Printed by the Ovid Bell Press, Inc, Fulton, Missouri 65251.

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Donald C. Barton, MD

Health System Reform

Health Care Reform. I am sure everyone is tired of hearing this phrase. It is really Health *System* Reform and it is strictly financially driven. However, reform will occur and we must be players in the game.

The Great Buddha was in the desert one day and saw a man crawling over the sand on his knees. This man had a boat on his back. The Great Buddha asked, "Why do you have a boat on your back?" The man answered, "I had to cross a lake 15 years ago." "You are in a great desert, remove the boat from your back." He did and he was *enlightened.*

We are entering the vast, unexplored desert of health system reform. We must get rid of our old baggage and help design this new way of delivering care, regardless of what Washington or Frankfort does.

We must change our old thinking processes and look at problems in a new way. The real frontier for reform should be community based. System reform, in order to work, will have to be from the bottom up, not the top down.

At the top, the Clinton Plan is a very complex proposal consisting of 1,364 pages. The heart of the bill is employer-mandated insurance and health alliances. Universal coverage would be phased in over a few years. A tremendously large bureaucracy would be created and financing, as presented, is untenable to any average-minded citizen. The bill attempts to have a solution for any problem in health care that might arise in the future.

It contains global budgets, which is just political rhetoric. Budgets must be based on costs, not theories, to be effective. Another part of this bill that is alarming is the criminal offense section. The giving of false information, regardless of intent, could result in jail, fines, and asset forfeiture for physicians. There is also mention of penalties for bribery in the bill to anticipate and curtail rationing of care.

The McDermott Bill is a single payer bill. It includes universal coverage, a tax on employers, an annual budget passed by Congress, and undisguised government manipulation at the center. The Cooper Bill is incremental, stresses managed care, and is an attempt at less bureaucracy. Michael's Bill offers coverage but doesn't mandate it. Graham's Bill is IRA based. All of the Republican-sponsored bills are rallying points for opposition to the Democrats, although parts of them may end up in a compromise bill, especially Senator Chaffee's.

The Rowland Bill is more conservative than Cooper's proposal. It contains insurance reform, some mandated coverage, a community health section, some antitrust provisions, and malpractice reform. It could play a role in a consensus bill. You have probably also read the

"We must change our old thinking processes and look at problems in a new way. The real frontier for reform should be community based. System reform, in order to work, will have to be from the bottom up, not the top down."

Starks Bill, which I think will be rewritten. Congressman Dingell is a player in this game and he will have a version out. Confused yet? I am.

This is a complex problem, as we all know. It cuts across party lines and state — federal relationships. There is a clash in philosophies, ie, either to change the system or to motivate change in the system. The real problem is that there are unlimited expectations versus limited resources. Prime ingredients are eligibility, benefits, and cost of delivery. You can't increase either of the first two without increasing the third. As the private system changes, Medicare will change. There will be less money and less access.

I predict that the final bill will be a consensus bill. It will move toward universal coverage and universal access. It will change how health care is delivered. We will have to revise our present relationships and make the necessary changes to accommodate. There *will be* a Health System Reform bill written by November the first. It *will be* called the Clinton Health Plan. We certainly hope that it doesn't even faintly resemble what was introduced.

As a final caution, let me quote an unknown scholar: "When you get in bed with the Federal Government, you have to expect more than a good night's sleep." One thing is certain. There will be continuous change for the next 6 months.

Donald C. Barton, MD
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It is important that you make your room reservations as soon as possible for this year's meeting by calling the Hyatt — 502/587-3434. ***Please be sure and indicate that you are attending the KMA meeting*** in order to receive ***the special convention rate*** of Single — $75/Double — $85.

Parking is readily available in downtown Louisville. The Hyatt offers enclosed parking for over 640 cars with additional parking available across the street and connected to the Commonwealth Convention Center by a covered walkway.

The Commonwealth Convention Center, located at 221 Fourth Avenue, will host KMA's General Sessions, specialty group meetings, and exhibit hall. The main registration desk will be located in the Convention Center. The Commonwealth Convention Center is one of the most functionally designed facilities of its kind with versatile lighting, computer climate control, and a sophisticated sound system. Complimentary coffee and danish, an exhibitor's lounge, and a snack bar will again be offered in the Exhibit Hall.

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The Hyatt Regency and Commonwealth Convention Center are both ideally located to take advantage of sightseeing, shopping, and dining, and downtown Louisville offers a wealth of things to see and do.

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Hepatocellular Carcinoma Presenting as a Mediastinal Mass

Ryland P. Byrd, Jr, MD; Thomas M. Roy, MD; Linda G. Korfhage, MD; Cheryl L. Fields, MD

From the Divisions of Respiratory Medicine and Pathology, University of Louisville School of Medicine and Veteran's Administration Medical Center, Louisville, KY.

We present a patient with hepatocellular carcinoma with systemic hematogenous metastases, but without parenchymal pulmonary involvement. Thoracic imaging revealed prominent mediastinal involvement. This pattern of hepatocellular tumor spread is unique.

Hepatocellular carcinoma is one of the most common cancers in the world.[1] Although it occurs uncommonly in Western Europe and the United States, the current incidence in North America is increasing.[2]

This tumor is highly aggressive and rapidly fatal. Median survival is measured in weeks to a few months from the time of diagnosis.[3] The patient is typically first seen at an advanced stage with extensive intrahepatic disease and distant metastases.[4] The pulmonary parenchyma is the most frequent site for tumor spread, while mediastinal lymph node involvement is less frequent. Hepatocellular carcinoma is found in the mediastinum in only 4.9% of affected patients at autopsy.[5]

We present a patient whose thoracic roentgenologic manifestation of hepatic carcinoma was unusual in that prominent mediastinal lymph node involvement occurred without pulmonary parenchymal seeding. This pattern of hepatocellular tumor spread has rarely been documented by premortem imaging and postmortem examination.

Case Report

A 44-year-old male was admitted to the Louisville Veterans Administration Medical Center for reevaluation of chronic osteomyelitis in his left foot incurred after a fall 1 year before admission. He had failed conservative treatment and had refused amputation on multiple occasions.

The patient had never used tobacco products or illicit drugs, but consumed ethanol daily. The patient had micronodular cirrhosis secondary to alcohol abuse proven by a liver biopsy on a previous admission. He denied abdominal pain, nausea, vomiting, or change in bowel habits. His wife stated that he appeared jaundiced during the 2 weeks prior to this hospitalization.

The patient was found to have scleral icterus, spider angiomas over his thorax, palmar erythema, and mild ascites. A three centimeter ulcer was present on the anterior lateral surface of his left foot and was draining a purulent material. His liver was percussed to 16 cm in the midclavicular line and was nontender. His temperature was 100.2°F. The remainder of his examination was normal.

The standard PA and lateral chest film documented the presence of an enlarged mediastinum, without suggestion of parenchymal or chest wall disease (Fig 1). Computerized tomography of the thorax was performed. This imaging modality further delineated the mediastinal mass, but failed to identify parenchymal lesions. No hepatic pathology other than macronodular cirrhosis and ascites was suggested. (Figs 2 and 3).

His hospital course was quickly complicated by sepsis syndrome. The patient expired prior to successful diagnostic intervention directed at explaining his mediastinal enlargement.

Macronodular cirrhosis and hepatocellular carcinoma with mediastinal, carinal lymph node, and bone marrow metastasis was demonstrated at autopsy (Figs 4 and 5). There was no evidence of pulmonary parenchymal metastasis despite intensive screening of histologic specimens.

Discussion

Hepatocellular carcinoma is associated with hepatic cirrhosis that may result from a variety of



Fig 1 — PA chest radiograph showing enlarged mediastinum.

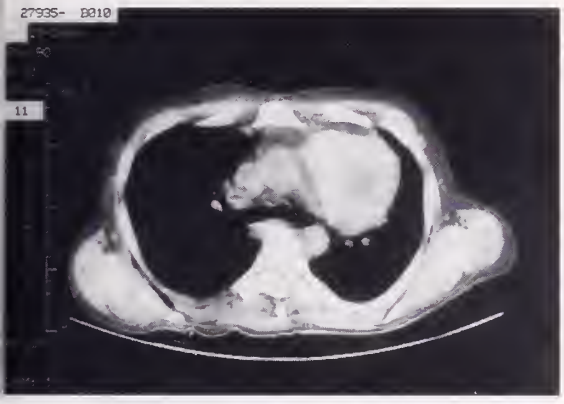


Fig 2 — CT of chest delineating the margins of the mediastinal mass.

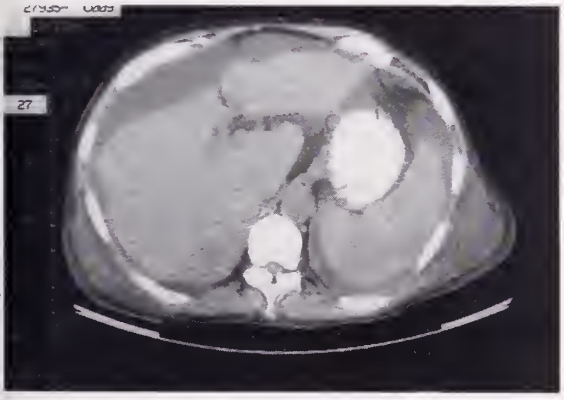


Fig 3 — Lower chest CT image suggesting macronodular cirrhosis and ascites.

predisposing factors such as viral hepatitides, hemochromatosis, mycotoxins, aflatoxins, and polyvinyl chloride.[6] The worldwide annual incidence is estimated to be as high as one million individuals.[7] In the United States, the incidence

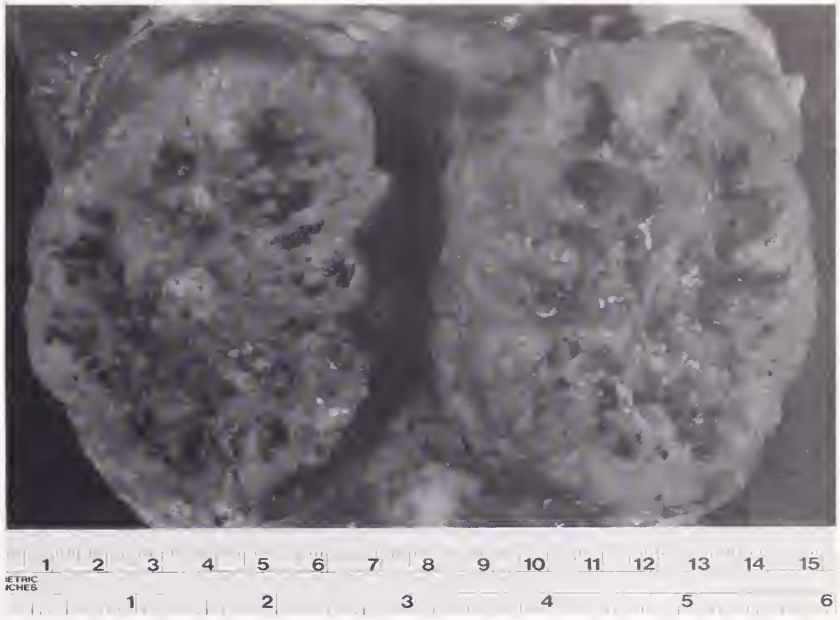


Fig 4 — Autopsy specimen of the fleshy and bosselated mediastinal tumor.

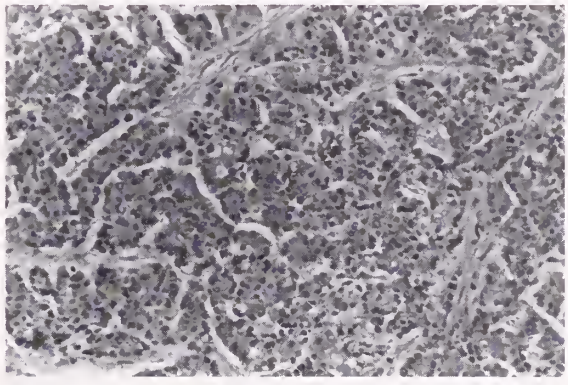


Fig 5 — Light microscopy identifying hepatocellular carcinoma cells arranged in an acinar pattern.

is 3.9 patients per 100,000 male population and 1.3 per the female population.[8]

The mean survival of a recently diagnosed patient with hepatocellular carcinoma is approximately 2 to 4 months. This poor survival time reflects the tumor's aggressive nature and propensity to spread hematogenously. Clinically, the most commonly recognized extrahepatic site of primary hepatocellular carcinoma metastasis is the lungs (38% of patients).[9] Autopsy studies document the presence of multiple bilateral pulmonary nodules with lower lung field predominance in as many as 52% of patients.[5]

In asymptomatic patients, nonspecific radiographic findings may suggest the presence of hepatomegaly and possible hepatoma. The most frequent radiographic abnormalities include elevation of the right hemidiaphragm, parenchymal nodules, lymphangitic carcinomatosis, miliary lesions, pleural effusions with or without concurrent pulmonary parenchymal lesions, and hilar adenopathy.[10-12]

Uncommon presentations include a single patient whose hepatocellular carcinoma caused a solitary cavitary pulmonary mass.[13] Another patient developed right heart failure and pulmonary hypertension secondary to multiple tumor emboli to the pulmonary vascular tree.[14]

Our patient is unique because he had premortem chest roentgenographic evidence of a bulky mediastinal mass without concomitant parenchymal involvement. The metastases of this tumor did not invade the pulmonary circulation. It is presumed that the mediastinal involvement was due to lymphangitic spread along diaphragmatic and periaortic lymphatics. No evidence of parenchymal lung involvement could be documented despite an intense search for microfoci. Other areas that are often seeded by the hematogenous route, such as the bone marrow and adrenal glands, were involved in our patient. To our knowledge this parenchymal sparing with significant mediastinal lymphadenopathy has not been previously reported. A single person has been described with metastatic hepatocellular carcinoma with negative pulmonary findings at autopsy.[15]

The unusual presentation of our patient may be an expression of the often emphasized observation that not all hepatocellular carcinomas share the same biologic behavior.[16] Investigators note differences in tumor activity when tumors are separated by histologic type, by causal etiology, by the coexistence of hepatic cirrhosis, and by the presence of certain serum markers such as alpha-fetoprotein.[2]

As therapies are being developed that may benefit patients with hepatocellular carcinoma,[17, 18, 19] the physician must maintain a high index of suspicion when risk factors are present. The possibility of metastatic hepatocellular carcinoma should not be overlooked in the differential of mediastinal lymphadenopathy.

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Diagnosis in Huntington Disease

Michael Gruenthal, MD, PhD; Walter L. Olson, MD

We present a case of Huntington disease made complex by lack of adequate family history. We survey the available diagnostic neuroimaging studies: CT, MRI, PET and SPECT. We briefly review the neurophysiologic investigations. We present the newly available information on the discovery of the Huntington disease gene. Direct testing for the gene without complex linkage analysis will now be available.

Huntington Disease is an autosomal dominant progressively disabling movement disorder of quick arrhythmic random flowing purposeless, but seemingly purposeful, facial, axial and limb actions.[1] The diagnosis, easy to make in the circumstance of obvious symptoms and a supportive and well documented family, is like traversing a quagmire when dealing with the orphan or individual separated from familial ties. For the past 10 years genetic markers have been available to assist in affirming the diagnosis, but require an adequate number of affected and unaffected relatives to be available for tracing the genetic location in the pedigree.[2] Imaging techniques and neurophysiologic studies can confirm the suspect diagnosis but there are no definitive clinical markers of the disease.

This report highlights the problems in the diagnosis of Huntington disease with a case we recently encountered. Based on recent medical literature, we outline fruitful diagnostic studies and highlight the direct genetic assessment of the patient.

Case Report

A 43-year-old caucasian male came to the Louisville VAMC for evaluation of difficulty walking. He gave a 6-year history of progressive difficulty controlling his movements, which began with a tendency to spill liquids. In particular, he was concerned about difficulty walking down stairs. He had resisted seeking medical attention, but came at the urging of his sister. He denied difficulty with cognitive, memory, or language functions, visual changes, dysarthria, dysphagia, weakness, sensory changes, headache, or seizures. He denied involuntary movements, but did acknowledge these when they were pointed out to him. He took no medications other than a nonprescription decongestant for seasonal allergy. He had no medical history other than an appendectomy at age 9.

He has no children. He has one sibling, a sister who is in good health and has three children. He stated that his father died of an MI in his late 30s, but his sister later disclosed that the death was due to an intentional drug overdose. He had no contact with his father after his parents divorced when he was a young child. When his mother remarried, he and his sister took their stepfather's surname. He described his mother, who lived in another state, as having chronic paranoid schizophrenia. He had no knowledge of other family members.

He held a clerical job in another state until 6 months prior to his presentation. He stated that his entire department had been laid off and that he had been unable to find work. He denied drug ingestion other than occasional alcohol and a 20-pack-year history of tobacco.

On examination his temperature was 36.9°C, BP 182/106, and pulse 104. General physical examination was unremarkable except for an old surgical incision in the right lower abdomen. He was alert and fully oriented. Language functions were intact. Memory, judgement, and insight appeared intact, but on digit span testing he was unable to repeat more than 4 digits forward or 2 digits backward. Cranial nerve examination was unremarkable but ocular dysmetria was not evaluated. Motor examination showed normal power bulk and tone. There were intermittent small choreic movements of the head, shoulders, hands, trunk, and feet. These occurred every 1 to 5 seconds and were occasionally camouflaged as purposeful movements. There was no tremor, dystonia, or bradykinesia. Muscle stretch reflexes were normoactive. Primary and cortical sensory functions were intact. No dysmetria, dyssynergy, or

Dr Gruenthol is Chief Resident ond Dr Olson is Associote Professor in the Deportment of Neurology, University of Louisville, ond Dr Olson is Chief of Neurology Service ot Louisville Veteron Affoirs Medicol Center.

dysdiadochokinesia were apparent when movements were not interrupted by chorea. His gait had an erratic weaving and dancing quality which was most notable with heel and toe walking. He was unable to stand on either leg independently or walk down a flight of stairs without holding the bannister.

Laboratory investigation including serum electrolytes, glucose, AST, ALT, ceruloplasmin, CBC, PT, PTT, ESR, TFTs, B_{12}, VDRL and UA were

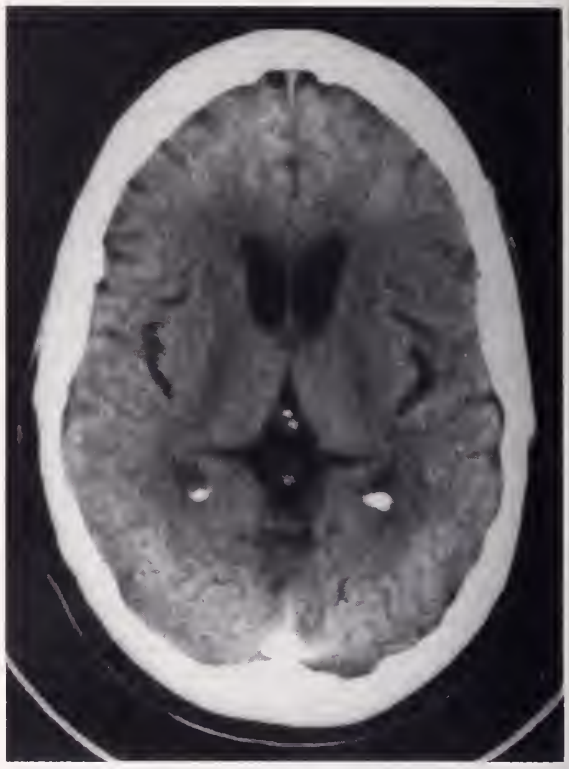


Fig 1 — CT scan in the plane of the caudate head. Nate volume loss of the caudate and balloaning af the ventricle. FH/CC ratia is 1.30 (see Ref 3).

all normal or nonreactive. EEG was normal. A CT scan of the brain showed pronounced volume loss of both caudate nuclei as well as mild to moderate cerebellar vermal and neocortical atrophy (Fig 1). MRI scan of the brain demonstrated marked atrophy of the head of the caudate nuclei, moderate cerebral cortical atrophy, mild cerebellar vermal atrophy, and some streaky increased signal in the putamen (Fig 2). A ^{99m}technetium HMPAO SPECT brain study showed absent uptake of nuclide in both caudate nuclei as well as small superficial areas of decreased uptake in both parietal cortices (Fig 3).

After discussing the importance of obtaining a detailed family history with the patient and his sister, they located two paternal cousins who confirmed the diagnosis of Huntington disease in their father. They then contacted their mother who conceded that their biological father had been given a diagnosis of Huntington disease based on clinical presentation and family history. The family pedigree, completed after he was discharged from the hospital, is shown in Fig 4.

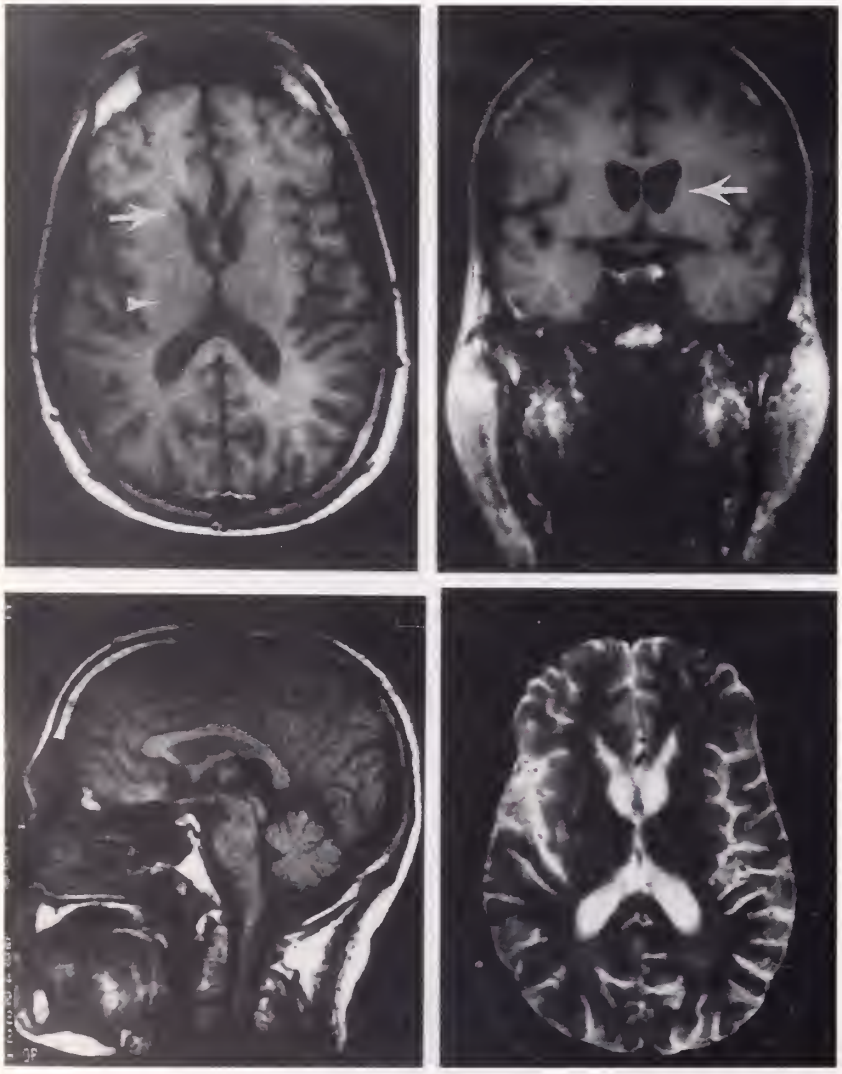


Fig 2 — MRI scan in transverse and caranal planes with T_1 weighting. Nate atraphy af caudate head, white arraw, and lacation of dorsal thalamic nuclei, white arrawhead. MRI scan in sagittal plane with T_1 weighting and transverse plane with T_2 weighting. Note mild vermal and cortical atraphy in the sagittal image and increased signal within the putamen in the transverse image.

Discussion

The clinical diagnosis of Huntington disease in the absence of a good family history requires a high index of suspicion and persistent inquiry. Thankfully the days of pneumoencephalography are over, but the lessons learned apply to newer imaging modalities. CT brain scanning will demonstrate the widespread cortical atrophy, caudate atrophy, and ventricular dilatation.[3] Cerebellum and brainstem atrophy has also been shown with CT imaging.[4] These features in the CT imaging of our patient certainly enhanced our suspicion of the disease.

The advent of MRI scanning of the brain has enhanced our understanding of the pathophysiology of the illness. As with CT scanning, this modality more easily identifies the caudate and cortical atrophy.[5] In patients with the akinetic-rigid form of the illness the putamen often has marked increased signal, greater than the adjacent cortex.[6] High field strength MRI scanning distinguishes an early and late phase of the illness. Because of T_2* effect there is low signal intensity in heavily T_2-weighted images in the globus pallidus, striatum, red nucleus, substantia nigra, and cerebellar dentate nuclei. Late phase Huntington patients display an increased signal intensity in the striatum and, occasionally, pallidum.[7] The paramagnetic effect of iron causes the T_2* effect, while late in the illness, gliosis so increases the signal intensity that the local paramagnetic effects are overwhelmed.[8] Cerebellar atrophy is clearly apparent, especially in the sagittal image of the vermis.

PET scanning is increasingly becoming a clinical tool. Imaging with ^{18}F-deoxyglucose, a marker of tissue metabolic rate, demonstrates an impaired or absent function in the caudate of affected individuals even when the caudates are normal by CT or MRI imaging criteria.[9] In at risk individuals the PET scan commonly shows decreased metabolic function for glucose in the caudate 1 to 4 years before onset of symptoms.[10] Studies with 5^{18}F-L-dopa have illustrated normal transport of dopamine to the striatum,[11] while N-methyl-^{11}C-spiperone scanning illuminate the loss of intrinsic striatal neurons that had dopamine D_2 receptors.[12]

In Huntington disease, ^{99m}Tc-HMPAO SPECT imaging shows decreased or absent uptake in the caudate of symptomatic patients.[13] Decreased nuclide uptake in parietal and frontal cortex is also seen.[14] Studies with the dopamine D_2 ligand, ^{123}I-S-(-)-iodobenzamide, have demonstrated absent or diminished receptor binding in the caudate and putamen.[15]

Electrophysiologic studies are of minimal benefit in the workup of Huntington disease. The EEG tends to demonstrate more frontal theta and delta slowing than in normals, but significant consistent slowing is not obvious until the patient has clear cognitive decline.[16] The cognitive evoked potentials become abnormal after the onset of the clinical manifestation and demonstrate a pro-

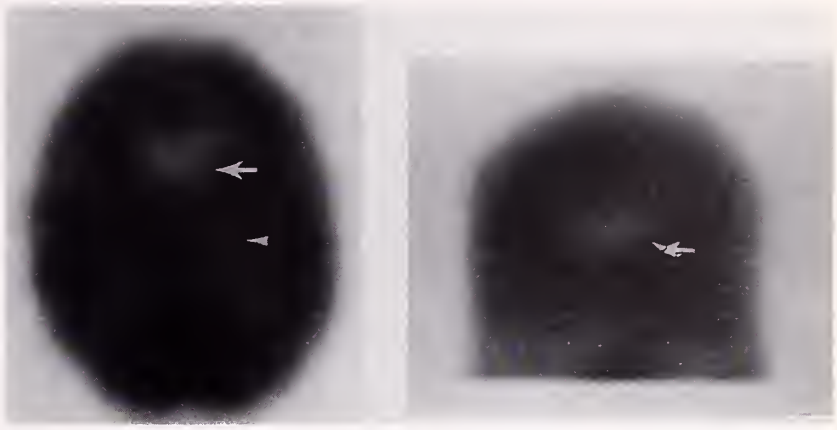


Fig 3 — SPECT scan in transverse and coronal planes. Note nuclide uptake in the thalamus, white arrowhead, and absence of uptake at the site of the caudate and putamen, white arrow.

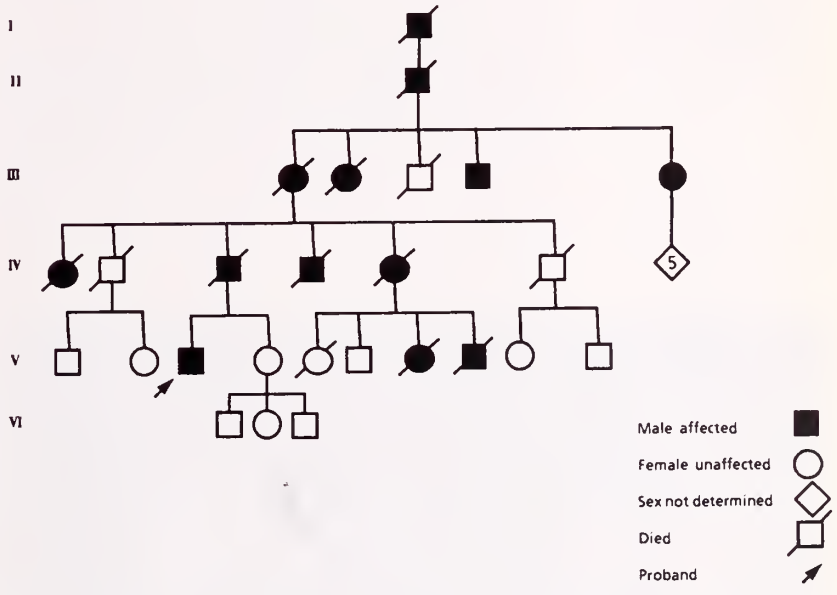


Fig 4 — Pedigree of the family obtained after patient's discharge from the hospital. The proband is V.3.

longation of the P3 latency.[17] SEP studies also tend to show small decrements in the amplitudes with preserved latencies,[18] and similar findings apply to the VEP testing paradigm as well.[19] ENG even early in the disease will show the obligatory eye-blink used to break fixation for the initiation of saccadic eye movements.[20] In the Westphal variant the slowed saccadic velocity will also be readily apparent. Saccadic decompensation of pursuit movements are also recorded in both the horizontal and vertical planes.

The technique with the greatest promise for accurate and definitive diagnosis has been the identification of the Huntington disease gene. Restriction fragment length polymorphic changes in the DNA of the tip of the short arm of chromosome 4 have been known for 10 years. Unfortunately, precise identification of the gene has eluded geneticists worldwide. Recently, the actual gene has been precisely identified, 4p16.3, with the specific abnormality a polymorphic trinucleotide repeat $(CAG)_n$ that is expanded and unstable. The gene product is a previously unidentified 348 kilodalton protein, with a variable glutamate repeat at the N-end commencing at about the 18th residue. This genetic abnormality is similar to that found in myotonic dystrophy $(CTG)_n$, spino-bulbar muscular atrophy $(CAG)_n$, and fragile X syndrome $(CGG)_n$. With the gene now identified, we can directly monitor the size of the trinucleotide repeat to make the diagnosis in anyone, eliminating the need for linkage analysis.[21]

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Crohn's Disease With Unusual Enterouterine Fistula in Pregnancy

Dennis Wulfeck, MD; Terry Williams, MD; Alka Amin, BA; Tsung-Yao Huang, MD

Pregnancy complicated by development of Crohn's disease is rare. The presentation of symptomatic Crohn's disease during pregnancy was initially described in 1946.[1] Crohn's disease has been described in a number of atypical locations and with development of unusual fistulas.[2]

The cases associated with pregnancy have in common a clinical picture of (1) delay in diagnosis, (2) frequent premature delivery, (3) surgical intervention during pregnancy, and (4) high fetal and maternal morbidity and mortality.[3-5] To our knowledge, this case is the first to describe the radiologic findings of an enterouterine fistula in a case of Crohn's disease beginning during pregnancy.

From the Department of Diognostic Rodiology, Humono Hospitol-University of Louisville, 530 S Jockson St, Louisville, KY 40202. 502/588-5875; FAX: 502/588-1754. Reprint requests to Tsung-Yoo Huong, MD, Associote Professor, Deportment of Diognostic Rodiology, University of Louisville, Louisville, KY 40292.

Case Report

An 18-year-old woman was hospitalized at the 28th week of pregnancy for preterm labor and persistent temperature of 102°F. She also complained of nausea, vomiting, and diarrhea 3 to 4 days prior to admission. On admission the leukocyte count was 9,200. An ultrasound performed revealed a singleton consistent with 28 weeks gestation and an estimated fetal weight of 1500 grams. The patient underwent exploratory laparotomy with findings of a periappendiceal abscess.

The patient was discharged eventually and returned a short while later in preterm labor. The patient underwent C-section for fetal distress and at that time was found also to have an interloop abscess. The patient recovered and was discharged home.

Approximately 2 weeks later, the patient was once again admitted with complaints of abdominal pain, fever, and purulent discharge from her vagina. CT scan of the abdomen, at this time, demonstrated concentric wall thickening and mild dilatation of several loops of bowel in the right lower quadrant with extensive streaking of the mesentery (Fig 1). A hysterosalpingogram was performed demonstrating a fistula communicating with the small bowel (Fig 2). A drain was placed into the uterus and the patient was placed on triple antibiotic therapy in response to positive cultures for *Entamoeba coli.* Additionally, the patient was placed on total parenteral nutrition. A repeat hysterosalpingogram, 2 weeks later, no longer demonstrated the fistulous communication between the bowel and uterus (Fig 3).

A GI work-up consisting of an upper GI and small bowel examination was performed and demonstrated segmental narrowing with mucosal irregularity of the terminal ileum (Fig 4). A repeat exploratory laparotomy was performed and demonstrated a severely inflamed terminal ileum with

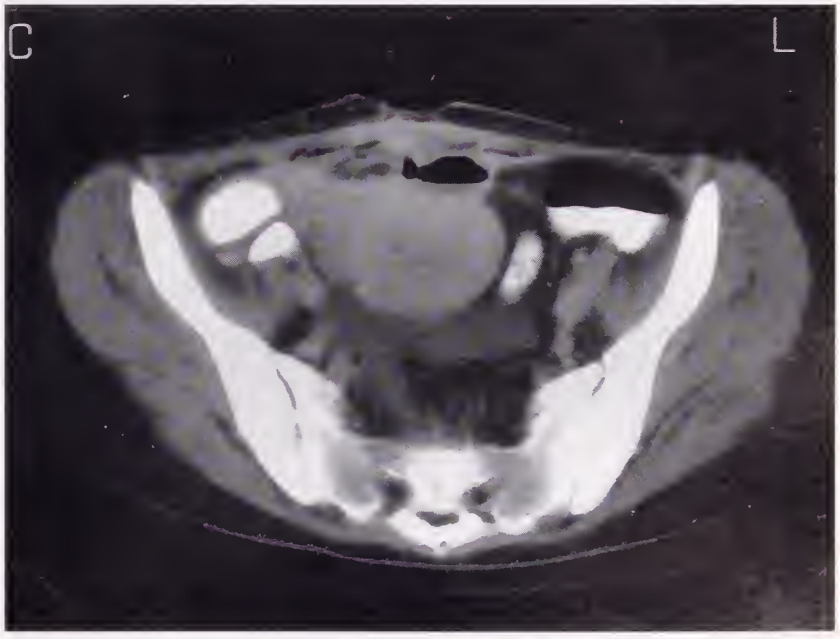


Fig 1 — CT of abdomen demonstrates bowel wall thickening with adjacent extensive inflammatory change of the right lower quadrant.

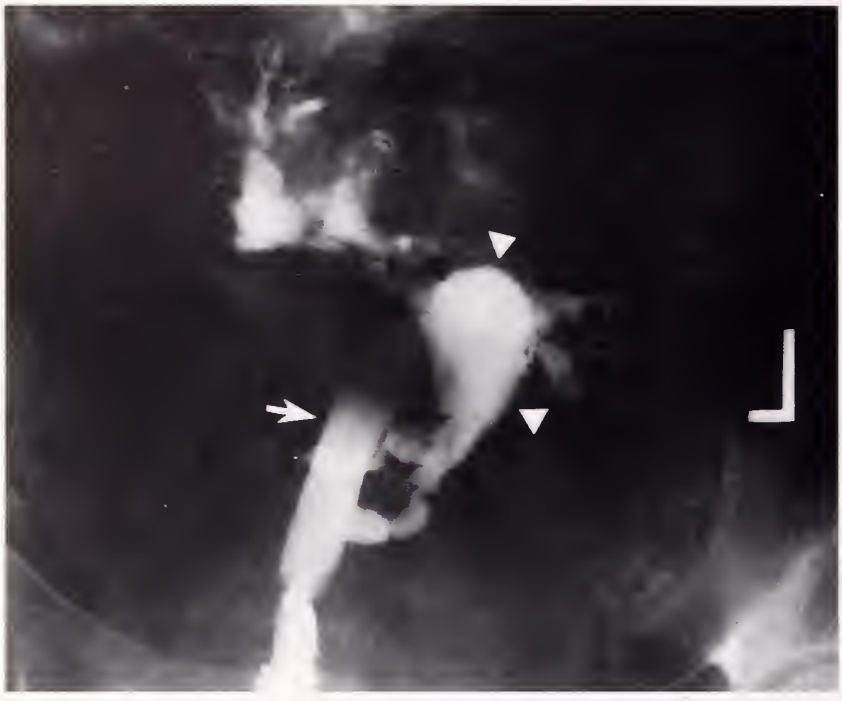


Fig 2 — Hysterasalpingagram demanstrates a "phantam uterus" carresponding to an abscess cavity (arrawhead) with spider-like fistulas ta the bawel and uterus (arraw). The uterus is partially apacified with preferential flaw thraugh cammunicating fistulas.



Fig 3 — Repeat hysterasalpingagram demonstrates residual small abscess cavity and fistula ta uterus. There was na bawel communication.

extensive adhesions. A resection was performed and the specimen pathologically confirmed Crohn's disease.

Discussion

Reports of Crohn's disease complicating the course of pregnancy are noted but are rare.[3-5] The complication rate is extremely high and infant mortality appears to be greater than maternal.[5] In this particular case, both the infant and mother survived.

The association with pregnancy is undetermined. This may represent a coincidental relationship or perhaps an autoimmune response. Development of fistulae are characteristic of Crohn's disease. Enteroenteric, enterocutaneous, and enterocolic fistulas are relatively common with Crohn's disease. Unusual fistulas of enterovesical, colovesical, colobronchial, and many more have been reported.[6,7] No reports of enterouterine fistula could be found in the literature.

Internal fistulas occur more frequently in patients with ileocolitis than in patients with small bowel involvement only.[6] Many sites of fistula formation have been described; however due to the rare occurrence of Crohn's disease in association with pregnancy, this case represents an unusual finding.

This case represents a good example of how pregnancy can mimic intestinal pathology. The initial working diagnosis was that of a perforation of the appendix. Temporary healing of fistulae occurred when the patient was placed on parenteral hyperalimentation supplemented by antibacterial treatment. Recurrence of symptoms when oral feedings were resumed may perhaps implicate intestinal motor activity in the reactivation of the disease. Enteric fistulae are not entirely specific for Crohn's disease and may also develop in other chronic enteric infections including tuberculosis and diverticulitis. There have been more than 100 complications reported of Crohn's disease, involving virtually every organ system.[6] The development of Crohn's disease during pregnancy has rarely been reported and the association is not proven. This particular complication of enterouterine fistula, to our knowledge, has not been reported. This case demonstrates the need to consider additional pathology in pregnant women with abdominal complaints.



Fig 4 — Small bowel examination demonstrates long segmental narrowing with mucosal irregularity of the terminal ileum (arrows).

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The Great Leap

Physicians have always been patients' advocates. Increasingly, to control an individual patient's health, physicians must become societal advocates, also. Now, even reimbursers have entered the societal advocacy arena. Their motivation is significantly different: cost containment and *self* preservation. In some instances, the distinction blurs between social advocacy and "Big Brother" intrusion.

In the movement toward managed care, physicians are the front line guardians of individuals, and large groups of individuals. They seek to protect not just access, but access of the appropriate quantity and quality of care as societal and financial factors emerge to discourage access to quality medical care.

Increasingly, physicians attempt to stem the societal causes of diseases and disorders which present for our management. Here in Jefferson County, the involvement of the Jefferson County Medical Society and the John Morgan Home is just one such positive example. In San Francisco, Physicians For A Violence-Free Society evolved in an effort to curb the incidence of urban violence. Frustrated with mending one bullet-ridden child after another, trauma doctors sought to affect the source of the injuries. As one involved surgeon at San Francisco General Hospital said, "We have run out of ways to decrease mortality, and what we're left with is prevention." Trauma surgeons not only lobby for gun control, but also spend time approaching youth organizations in high risk neighborhoods surveying their involvement in violence and looking for anti-violence initiatives.

Of course, this is hardly altogether new. In the 1950s and 1960s, it was physicians, led by a Kentucky physician, that led the movement to enhance safety in our cars. Safety glass, padded dashboards, and seat belts were developed and became mainstream standards saving countless lives and forever changing our expectations for highway safety in a positive way.

"Physicians must increasingly take a lead in addressing how society impacts on and creates the medical problems we deal with. This is not altogether new, but the potential vastness of scope is."

This same trend in action is also evident at the federal level in the approach the Attorney General has espoused. Attorney General Janet Reno has frequently articulated her viewpoint that stemming violence on our streets ultimately requires taking the initiative in raising and educating preschoolers!

On the other hand, we have long known the role tobacco and alcohol use play in filling our hospitals with extremely debilitated and complicated cases. For many years, wellness initiatives, often spearheaded by physicians, have attempted to prevent disease by discouraging tobacco and alcohol use, but the stakes have increased recently. Third party payors are redefining the standards of acceptable behavior. Some employers require their employees be smoke-free in *and out* of the workplace. They point to the well documented lower medical costs sustained to justify such actions which would otherwise clearly be considered an intrusion of privacy.

Most aggressive of all has been the initiative Medicaid has taken in Florida. Medicaid is seeking reimbursement *from tobacco companies* for treatment of medical disorders related to tobacco use. Enabling legislation has been passed, but not yet signed, to permit Florida's attorney general to sue tobacco companies in an extended application of the federal law which requires states participating in Medicaid "to try to collect whatever medical costs they can from third parties who may be liable." All eyes are on Florida, since this bill is in no way limited to tobacco companies.

Physicians must increasingly take a lead in addressing how society impacts on and creates the medical problems we deal with. This is not altogether new, but the potential vastness of scope is. Some cases are clear: societal advocacy reducing risk factors resulting in improved quality of life and, indeed, increased longevity. Others raise the concern of excessive intrusion and the fear of "Big Brother watching." Any way we look at it, it is as Dr Robert C. Mackersie, head of the trauma unit at San Francisco General Hospital, was quoted as saying in the *New York Times* last fall, "For surgeons to make the jump from hard science to this morass that most of us view as the social sciences is a big leap."

Martha K. Heyburn, MD



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Managing Your Psoriasis

Nicholas J. Lowe, MD
Westwood Squibb
100 Forest Avenue
Buffalo, NY 14213-1091

This is a resource guide for a patient with psoriasis. Dr Nicholas J. Lowe discusses the diagnosis and care of this skin disease with a tender touch. His experience managing patients and years of teaching physicians is distilled into this compact "how to" book. The initial chapters discuss the basics, from the initial presentation to etiologies. He sprinkles words of encouragement, with facts to support and references to read. His relationship with the National Psoriasis Foundation functions as a telecommunication vehicle for his work. He does not avoid detail and busily discusses psoriasis in isolated and specific sites, in the adnexae of nails and hair, and in various age groups. Helping psoriatic arthritis and other internal manifestations of psoriasis connects multiple medical specialties, and this is emphasized to encourage patients interaction with their personal physician.

Treating psoriasis means mastering topical and systemic therapies. Such a spectrum means that tailoring is a necessity. Old standby tar still has a place, and ultraviolet light comes and goes in popularity. Innovations such as PUVA (psoralens plus ultraviolet A) have proved effective, not universally, but certainly in some cases. Dr Lowe details this information, with pros and cons and with honesty. More potent medicine in the form of orals or injectables means laboratory work and communication with all physicians involved in the case. This outline reads well and makes the physician better informed, in addition to the patient.

Several case studies at the end of the didactic information introduce an epilogue-like question and answer section. Dr Lowe appends multiple resources, complete with name and address, for the consumption of the reader and the physician. Even if well informed, the reader will like this handy book. The price is right and the information is plentiful.

Alex's Journey

The story of a child with a brain tumor

Written and published by the
American Brain Tumor Association
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Des Plaines, IL 60018

The American Brain Tumor Association wrote this book for the child reader, but meant it also for the parents. Its soft back, drawn pictures, and large print disguise a specific purpose — the education of the patient and family. Pages of material discuss the process of diagnosis, taking the history from a young historian and subjecting him or her to the tests. It reduces the x-ray suite to a metal playhouse, complete with different televisions and movies. Chapters deal with treatment, whether surgery or radiation, and the accompanying side effects. The authors gently consider the pain and suffering, not only for the patient, but also for the family. This benevolent organization makes this small paperback available from the American Brain Tumor Association, 2720 River Road, Des Plaines, IL, 60018. Reading it is humbling, yet comforting. Being helped is the purpose, and it is well accomplished.

Stephen Z. Smith, MD
Book Review Author

Be A Physician

TO THE EDITOR: On April 6-7, the Department of Anesthesia and Critical Care of the University of Kentucky gave a 2-day Forum on Health Care Rationing.

This was a stimulating, fascinating discussion of forbidden subjects by leading members of the medical community from across the nation, without exception all skilled speakers.

It was clear that whatever "informal" rationing we have is better than what we are apt to face if the government and lawyers get involved with this Gordian Knot.

The "codified" charts of allocating patients into or getting them out of ICU units made Senator Dole's chart on Clinton's Health Plan look primitive.

One could not help but to turn one's thoughts on how to avoid such an Orwellian progression. The best way would be to relieve the economic pressure, cut down on unnecessary services.

"Unnecessary services" is clearly defined by whose ox is being gored.

Whatever I now say will clearly step on toes.

We need to step forward and be physicians to our patients; not high-tech doctors surrounded by our machines that keep nonfunctioning units of protoplasm alive without consideration for quality of life.

Two areas come to mind. First the enormous number of our people being transported three times a week from nursing homes to dialysis centers. I am not speaking of delightful Aunt Susie, who is alert, entertaining, and fun. But of those "ghosts" who are senile, contracted, blessed with bed sores and gastroscopy tubes. Surely, one of us could be a physician, sit down with the family (Medicare does not pay for such conferences) and arrive at the obvious conclusion. Stop!

Secondly, the use of gastroscopy tubes to prolong the agony of similar individuals. We surgeons should have long heart-to-heart family conferences on this subject. Stay our hands.

One is aware of nursing home rules, state policies, and other mindless bureaucratic hurdles to prevent "abuse." However, no one but a true physician has the ability to make families face the fact that such treatment is undesirable, and a perversion of our mission; to prolong a "worthwhile"* life, alleviate suffering, and above all Do No Harm. There will be those who may violently disagree — one supposes that our definition of "life" is different. Think about it — be a physician!

James B. Holloway, MD
Lexington, KY

*My word



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Traditionally, cities and rural areas of Kentucky have their greatest number of new physicians arrive and begin their new practices in the months of June and July. This year will again see many new physicians moving into areas of the state. We want to welcome each of these physicians. The KMA Alliance would like to welcome each new spouse and invite them to become a part of our state and national Alliance organizations. Some areas of the state have local organizations and if any physician spouse moves into one of these areas, we hope he or she will become a member of the local Auxiliary/Alliance. Our organized counties are, BOYD, DAVIESS, FAYETTE, HENDERSON, HOPKINS, JEFFERSON, McCRACKEN, PERRY, PULASKI, ROWAN, WARREN, WHITLEY, AND NORTHERN KY.

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With the many changes that are taking place in medicine today in our state and nationally, it is very important that we all join together as a unified organization. The future of medicine is in our hands, and we must act now.

To become a member of the Kentucky Medical Association Alliance and the American Medical Association Alliance, please complete the form below and mail today with a check for $40.00, made payable to KMAA, to 301 N Hurstbourne Pkwy, #200, Louisville, KY 40222-8512.

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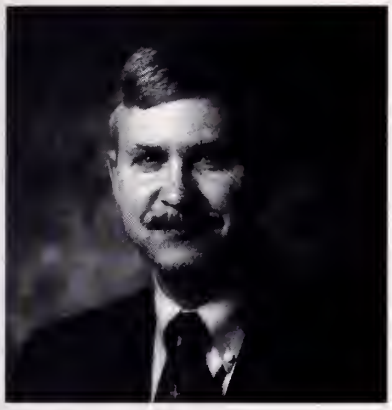
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Larry P. Griffin, MD

Larry P. Griffin, MD, Director of Program Services at The American College of Obstetricians and Gynecologists (ACOG), has been honored by the College for outstanding service and leadership in the field of obstetrics and gynecology.

The award, presented at ACOG's 42nd Annual Clinical Meeting in Orlando, FL, is given annually to the physician who has done the most for the specialty within his or her District.

Dr Griffin has been committed to various other medical organizations, having been President of the Louisville OB/GYN Society and the Jefferson County Medical Society. He has chaired the Kentucky Family Planning Task Force and the KMA Committee on Continuing Medical Education, and served on the Jefferson County Council on Drug Abuse.

Michael D. Hagen, MD, has been elected to a one-year term as Treasurer of the American Board of Family Practice (ABFP). Dr Hagen is an Associate Professor in the Department of Family Practice at the University of Kentucky in Lexington.

Several KMA members were included when the University of Louisville announced recent promotions — **Carol A. Hansen, MD,** to assistant professor in anesthesiology; **Nemr S. Eid, MD,** to associate professor of pediatrics; **Sunny A. Joseph, MD,** associate professor in cardiology; and **Marcus F. Stoddard, MD,** associate professor in cardiology.

Charles C. Barr, MD, was the recipient of a Distinguished Teaching Award at the recent University of Louisville commencement ceremony. Dr Barr, described as "a skillful and enthusiastic teacher who is committed to the education of residents and students," won the award for professional education. He is a professor of ophthalmology and visual sciences.

Suburban Medical Center has announced medical staff officers for 1994. They are: **Robert Schiavone, MD,** president; **Glenn E. Lambert, Jr, MD,** president-elect; **W. Ken Kleinsteuber, MD,** secretary-treasurer; and **Paul Schneider, MD,** past president.



J. Douglas Knoop, MD

J. Douglas Knoop, MD, has been awarded the 1994 David A. Winston Fellowship. In June, he will leave his practice at the Lexington Clinic to study health policy development in the nation's capital for 9 months.

After earning his bachelor's and master's degrees from the University of Louisville, Dr Knoop entered UK to study for his MD. He served his residency at Bowman Gray School of Medicine of Wake Forest University, specializing in ear, nose and throat surgery. In 1980, Dr Knoop joined the medical staff of the Lexington Clinic. In December, he earned his master's degree in health administration from UK.

Dr Knoop will be arriving in Washington at a time when the debate over healthcare reform is heating up. During his first few weeks, he'll spend much of his time meeting with senators, congressmen, their health aides, and members of special interest groups — all valuable contacts for the future, he believes.

David Winston fellows are free to choose a special area of concentration for their study. The current fellow is helping a senator write an alternative healthcare plan, said Dr Knoop.

Although he doesn't know yet what direction his career will take once the fellowship ends, Dr Knoop doubts he'll return to clinical medicine.

"Personally, I would love to work at the national level with a government agency or with a special interest group," he said. "If more doctors could be trained like this, maybe we could make more of an impact. Hopefully, I'm one of a new breed."

Dr Knoop is a fellow of the American College of Surgeons and of the American Academy of Otolaryngology. He is board certified in otolaryngology.

UPDATES

Kentucky Physicians Practicing Outside of Kentucky

The Kentucky Medical Association is

interested in tracking the number of physicians who have decided to practice outside of Kentucky or who were interested in locating in Kentucky but did not because of the 2% provider tax or other onerous health care reform provisions enacted by the Kentucky General Assembly.

If you are aware of physicians who fall into either of the aforementioned categories, please contact the KMA Trustee in your area or the KMA Headquarters Office at 502/426-6200.

UK's Accredited Vascular Lab Saves Lives in Kentucky

According to the University of Kentucky, cardiovascular disease can be prevented with early detection through the use of noninvasive vascular testing. The vascular laboratory at the University of Kentucky Hospital was among the first 400 vascular laboratories in the US, Canada, and Puerto Rico to be granted accreditation by the Intersocietal Commission for the Accreditation of Vascular Laboratories. Accreditation signifies that the UK facility has been reviewed by an independent agency.

1994 KMA Dues Fully Deductible as Business Expense

The Revenue Reconciliation Act of 1993 has added a provision to the Internal Revenue Code denying deduction of expenditures for "lobbying" as business expenses. As such, associations such as KMA are now required to notify members, when dues are solicited or paid, of the portion of dues the organization reasonably believes will be spent on lobbying. This amount may not be deducted as a business expense.

This change in tax law became effective January 1, 1994. However, KMA has utilized an option authorized by the IRS to waive the nondeductibility of dues paid for 1994 and to combine the 1994 and 1995 dues billing cycle.

As a result of KMA exercising the option described above, all KMA dues for 1994 are fully deductible as a business expense for federal income tax purposes. An appropriate percentage of deductibility will be calculated by KMA and provided to members in the 1995 dues billing cycle. Should you have any questions, please contact the KMA Headquarters Office at 502/426-6200.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Boyle

Charles G. Campbell, MD — R
204 S Second St, Danville 40422
1948, U of Michigan

Fayette

James W. Akin, MD — REN
1740 Nicholasville Rd, Lexington 40503
1985, U of Kentucky

David E. Cowen, MD — OPH
KY Clinic E308, Lexington 40536
1988, U of Kentucky

Russell M. Eldridge, MD — HEM
1628 Nicholasville Rd, Lexington 40503
1982, U of Tennessee

Steven L. Hoover, MD — N
1725 Harrodsburg Rd #M, Lexington 40504
1988, U of Arizona

Louis J. Kroot, MD — EM
UKMC, M53, Lexington 40536
1974, Georgetown

William J. Lester, MD — PMR
2050 Versailles Rd, Lexington 40504
1979, West Virginia U

Eric J. Levine, MD — IM
3469 Warwick Ct, Lexington 40517
1987, Med U of So Carolina

Samuel C. Matheny, MD — FP
KY Clinic K312, Lexington 40536
1967, U of Kentucky

Terence W. O'Neill, MD — IM
1401 Harrodsburg Rd #B160, Lexington 40504
1989, U of Kentucky

Sandra L. Roberts, MD — AN
3320 Tates Creek Rd, Lexington 40502
1980, U of Kentucky

Graves

Ruben Cuadrado, MD — GE
1029 Medical Ctr Cir #403, Mayfield 42066
1976, Cornell

Gary A. Gallo, MD — ORS
PO Box 372, Mayfield 42066
1963, New York Med Coll

Henderson

Joseph H. Harpole, Jr, MD — R
1305 N Elm St, Henderson 42420
1986, E Tennessee U, Johnson City

Donald F. Knudsen, MD — S
1725 N Green St, Henderson 42420
1964, Tufts

Pravin C. Mehta, MD — ONC
110 N Water St, Henderson 42420
1973, L T M Med Coll, Bombay

Rodney Porro, MD — PTH
1305 N Elm St, Henderson 42420
1956, Indiana U

Geoffrey D. Sloan, MD — AN
2382-C Wood Dr, Henderson 42420
1985, Med Coll of Virginia

Jefferson

Jaime E. Montalvo, MD — EM
PO Box 6366, Louisville 40206
1980, U Central del Este, Dominican Rep

Mark H. Orgel, MD — FP
5721 Bardstown Rd, Louisville 40291
1984, U of Texas, Galveston

Punita Rastogi, MD — IM
425 S Hubbards Ln, Louisville 40207
1987, Bangalore Med Coll, India

Thomas A. Scott, MD — IM
4736 W Broadway, Louisville 40211
1982, Meharry Med Coll, Nashville

Madison

Harold R. Hobe, MD — IM
114 Forest St, Berea 40403
1965, U of Pittsburgh

Nicholas

Jose T. Lorenzo, MD — GP
2300 Concrete Rd, Carlisle 40311
1969, U of Santo Tomas

Woodford

Michael J. Growse, MD — GP
360 Amsden Ave, #202, Versailles 40383
1974, U of Western Ontario

Whitley

Janice M. Kunkel, MD — PD
1400 Cumberland Falls Hwy, Corbin 40701
1990, U of Missouri

In-Training

Fayette

James E. McDermott, III, MD — PTH
Donna M. Skinker, MD — PTH

Jefferson

David A. Bergamini, MD — S
Deborah L. Copeland, MD — FP
John R. Dykes, II, MD — S
Thomas M. Grayson, MD — S
Charles M. Littlejohn, MD — IM
Norman O. Moser, DO — IM
Clara A. Striegel, MD — PD

Kenton

G. Leroy Gallenstein, MD — FP
Robert L. Wyenandt, Jr, MD — FP

DEATHS

Stephen B. Kelley, MD
Somerset
1936-1994

Stephen B. Kelley, MD, a family practitioner, died May 2, 1994. A 1962 graduate of Ohio State University College of Medicine, Dr Kelley was an active member of KMA.

Claude C. Waldrop, MD
Williamstown
1903-1994

Claude C. Waldrop, MD, a retired general practitioner, died May 10, 1994. Dr Waldrop was a 1942 graduate of the University of Louisville School of Medicine and a life member of KMA.

J. Ray Bryant, MD
Marco Island, FL
1917-1994

J. Ray Bryant, MD, a retired thoracic surgeon, died May 31, 1994. A 1942 graduate of the University of Louisville School of Medicine, Dr Bryant was a life member of KMA.

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates to KMA members: $10 per insertion up to 50 words, 25¢ each additional word. To non-members; $30 per insertion up to 50 words, 25¢ each additional word.

Send advance payment with order to: The Journal of KMA, 301 N Hurstbourne Pky, Ste 200, Louisville, KY 40222.

KENTUCKY, LOUISVILLE: MEDICAL DIRECTORSHIP OPPORTUNITY — Seeking Board Certified Emergency Medicine physician to practice in the "Home of the Kentucky Derby." Enjoy a reputation of excellence in a new ED. 12,000 patients annually — 274-bed facility. Located 100 miles from Cincinnati, OH and 175 miles from Nashville, TN. Competitive clinical fees. Monthly stipend and benefits available for the Director. For additional information, please call Sheila Pace, Coastal Emergency Services of Memphis, Inc. at 1/800/777-1301.

PA/NP RECRUITMENT ASSISTANCE — The University of Kentucky Medical Professions Placement Service now offers assistance in the recruitment of physician assistants and nurse practitioners in addition to physician placement. Qualified candidates possessing a variety of backgrounds and experience are available. For more information on how we can help you, please contact: Beth Shedd, UKMPPS, 202 H.S.L.C., Lexington, KY 40536-0232, phone 606-323-6842/800-288-0658.

OFFICE FOR RENT OR FOR SALE — Franklin, KY, 20 miles south of Bowling Green, KY, and 40 miles north of Nashville, TN. Office fully equipped. Good location across from hospital. Contact Dr D. Alvey 502/586-6114 or 586-6075.

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These Pfizer/Roerig/Pratt & Searle pharmaceuticals may be prescribed and dispensed under the program:

Pfizer Labs

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Diabinese® Tablets (Chlarprapamide) Rx
Diabinese® Tablets Unit-Dase Pak (Chlarprapamide) Rx
Feldene® Capsules (Piraxicam) Rx
Feldene® Capsules Unit-Dase Pak (Piraxicam) Rx
Minipress® Capsules (Prazasin HCl) Rx
Minipress® Capsules Unit-Dase Pak (Prazasin) Rx
Minizide® 1 Capsules (1 mg. Prazasin and 0.5 mg. Palythiazide) Rx
Minizide® 2 Capsules (2 mg. Prazasin and 0.5 mg. Palythiazide) Rx
Minizide® 5 Capsules (5 mg. Prazasin and 0.5 mg. Palythiazide) Rx
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Narvasc® (2.5, 5 and 10 mg.) Rx
Renese® Tablets (Palythiazide) Rx
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Sustaire® (Theaphylline anhydraus) Rx
Terramycin® Capsules (Oxytetracycline HCl) Rx
Vansil™ Capsules (Oxamniquine) Rx
Vibra-Tabs® (Daxycycline hyclate) Rx
Vibra-Tabs® Unit-Dase Pak (Daxycycline hyclate) Rx
Vibramycin® Calcium Syrup (Daxycycline calcium aral suspensian) Rx
Vibramycin® Hyclate Capsules (Daxycycline hyclate) Rx
Vibramycin® Hyclate Capsules Unit-Dase Pak (Daxycycline hyclate) Rx
Vibramycin® Manahydrate far Oral Suspensian (Daxycycline manahydrate) Rx
Vistaril® Capsules (Hydraxyzine pamaate) Rx
Vistaril® Capsules Unit-Dase Pak (Hydraxyzine pamaate) Rx
Vistaril® Oral Suspensian (Hydraxyzine pamaate) Rx
Zithramax® Capsules (Azithramycin)

Roerig

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Atarax® (Hydraxyzine HCl) Rx
Atarax® Tablets Unit-Dase Pak (Hydraxyzine HCl) Rx
Banine® Chewable Tablets (Meclizine HCl) OTC
Cardura® Tablets (Daxazasin Mesylate) Rx
Cefabid® (Cefaperazane sadium) Rx
Diflucan® (Flucanazane) Oral and Parenteral Antifungal Rx
Diflucan® (Flucanazane) Unit-Dase Pak Oral and Parenteral Antifungal Rx
Emete-can® IM/IV (Benzquinamide HCl) Rx
Geocillin® (Carbenicillin indanyl sadium) equivalent ta 382 mg. carbenicillin Rx
Geopen IM/IV (Carbenicillin disadium) Rx
Heptuna® Plus Capsules (Iran plus vitamins and minerals) Rx
Hydracartisane Pawder (Hydracartisane USP micranized) Rx
Isoject® Permapen® (Penicillin G benzathine) Aqueaus Suspensian Rx
Marax® (Hydraxyzine HCl [ATARAX®]-Theaphylline-ephedrine suffate) Rx
Navane® Capsules (Thiathixene) Rx
Navane® Capsules Unit-Dase Pak (Thiathixene) Rx
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Navane® Intramuscular (Thiathixene HCl) Rx
Pfizerpen® far Injectian (Penicillin G patassium) Buffered Rx
Pfizerpen®-AS (Penicillin G pracaine) Aqueous Suspensian Rx
Palymyxin B Sulfate Sterile Rx
Sinequan® Capsules (Daxepin HCl) Rx
Sinequan® Capsules Unit-Dase Pak (Daxepin HCl) Rx
Sinequan® Capsules Unit af Use Pak (Daxepin HCl) Rx
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Pracardia® Capsules (Nifedipine) Rx
Pracardia® Capsules Unit Dase Pak (Nifedipine) Rx
Pracardia XL® (Nifedipine) Extended Release Tablets Rx
Pracardia XL® (Nifedipine) Extended Release Tablets Unit-Dase Pak Rx
Zalaft® Tablets (Sertraline) Rx

Searle

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Aldactane® tablets (spiranalactane)
Calan® SR caplets (verapamil HCl)
Calan® caplets (verapamil HCl)
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Kerlane® tablets (betaxalal HCl)
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Gentacidin® Salutian and Ointment (gentamicin sulfate)
Gentamicin 40 mg/ml, 80 mg/2 ml (far injectian)
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Vasacan-A Ophthalmic Salutian (naphazaline HCl-antazaline phasphate)
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Nizaral® Cream (ketacanazale)
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*Tylax® Capsules (axycadane hydrachlaride and acetaminaphen capsules USP)
Vascar® Tablets (bepridil HCl)

Ortho Biotech

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Terazal® Cream and Vaginal Suppasitaries (tercanazale)
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Meclan® Cream (meclacycline sulfasalicylate)
Manistat Derm® Cream (micanazale nitrate)
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Retin-A® Cream/Gel/Liquid (tretinain)
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Enduranyl® Tablets (methyclathiazide and deserpidine)
E.E.S. 400® Filmtab® (erythramycin ethylsuccinate tablets, USP)
E.E.S.® Granules (erythramycin ethylsuccinate far aral suspensian, USP)
E.E.S.® 200 Liquid (erythramycin ethylsuccinate aral suspensian, USP)
E.E.S.® 400 Liquid (erythramycin ethylsuccinate aral suspensian, USP)
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Eryped® Chewable Tablets (erythramycin ethylsuccinate tablets, USP)
Eryped® Draps (erythramycin ethylsuccinate far aral suspensian, USP)
Eryped® 200 (erythramycin ethylsuccinate far aral suspensian, USP)
Eryped® 400 (erythramycin ethylsuccinate far aral suspensian, USP)
Ery-Tab (erythramycin delayed-release tablets, USP, enteric-caated)
Erythracin® Stearate Filmtab® (erythramycin stearate tablets, USP)
Erythramycin Base Filmtab® (erythramycin tablets, USP)
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Fera-Gradumet® Filmtab (cantralled-release dase af iran)
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Iberet®-500 Liquid Oral Salutian (iran, B-camplex vitamins and vitamin C)
K-Lar™ 20 mEq. Pawder Packets (patassium chlaride far aral suspensian, USP)
K-Lar™ 15 mEq. Pawder Packets (patassium chlaride far aral suspensian, USP)
K-Tab® 10 mEq. (750 mg.) (patassium chlaride extended-release tablets, USP)
Ogen® Vaginal Cream (estrapipate vaginal cream, USP)
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Ogen® 2.5 Tablets (estrapipate tablets, USP)
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PCE® 500 mg. Tablets (erythramycin particles in tablets)
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VI-Daylin® Multivitamin + Iran Chewable Tablets
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VI-Daylin® ADC Vitamins Draps
VI-Daylin®/F Multivitamin Draps
VI-Daylin®/F ADC Vitamins Draps
VI-Daylin® Multivitamin plus Iran Draps
VI-Daylin® ADC Vitamins plus Iran Draps
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VI-Daylin® Multivitamin Liquid
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Novo Nordisk

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Navalin® L
Navalin® N
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Navalin® N PenFill®
Navalin® 70/30 PenFill®

HUMAN INSULIN (semi-synthetic)

Velasulin® Human
Insulatard® Human
Mixtard® Human 70/30

PURIFIED INSULIN

Regular-R
Lente® L
NPH-N
Velasulin® R
Insulatard® N
Mixtard® 70/30

STANDARD INSULIN

Regular-R
Lente® L
NPH-N
Semilente® S
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Borren
Ely Drugs, Inc
Glasgaw Prescriptian Center
K-Mart Pharmacy
Tawne & Cauntry Drugs

Bell
City & Caunty Drug
Farris Drugs
Jeff's Pharmacy
K-Mart Pharmacy
Krager Campany
Pineville Has. Out-Pt Pharmacy
Rxca Friendly Pharmacy
SuperX Drugs
Tatal Ɪɛ Care Pharmacy

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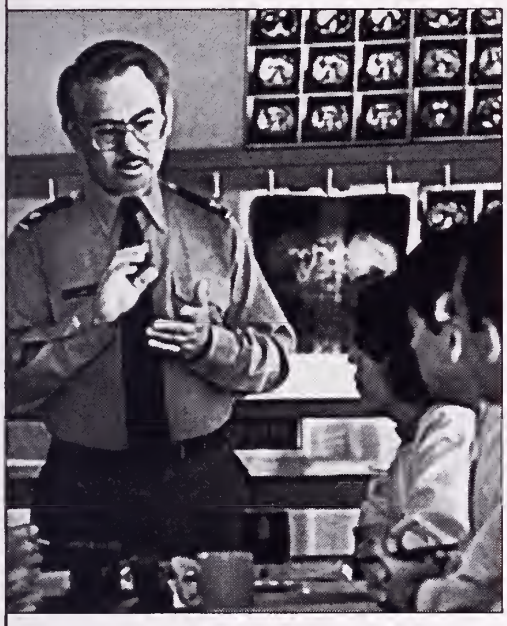
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COVER: "The Art of Medicine" is the theme of this year's Kentucky Medical Association Annual Meeting, scheduled for September 19-22 at the Hyatt Regency Louisville. This month's cover introduces a complete preliminary program for this not-to-be-missed event. Diversity has always marked the scientific sessions of the Annual Meeting. With the many specialties that sponsor programs during the meeting, attendees can choose from a wide variety of topics, speakers, and lecture formats.

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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Second-class postage paid at Louisville, KY and additional offices. Yearly subscription rates: $25 domestic; $30 foreign. Single issues $3 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association*, 301 N Hurstbourne Pkwy, Suite 200, Louisville, KY 40222-8512. EDITORIAL AND ADVERTISING: Telephone 502/426-6200.

Listed in Index Medicus. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

National advertising representative: State Medical Journal Advertising Bureau, Inc, 11437 W 106th St, Overland Park, KS 66214, phone 800/788-2360.

The *Journal*, its editors, and the Kentucky Medical Association do not assume responsibility for the opinions and statements of its contributors and advertisers. The *Journal* reserves the right to make the final decision on all content and advertisements.

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Reflections & Directions

Amidst the continued health systems reform debate on Capitol Hill and the implementation of our own health systems reform bill (HB 250), physicians perhaps feel "spent" and still perplexed as to what will be the end products. The key buzz words: managed care, universal access, antitrust initiatives, tort and liability reform, insurance reform, cost containment, and any willing provider, to name a few, have taken on definite new meanings for all of us and the implications for the practice of medicine are becoming better defined.

Interestingly, until several months ago, many state legislative bodies were boldly forging ahead with legislation, but now funding reasons and a host of other problems have dampened the enthusiasm for reform. This perhaps bodes ill for what may happen at the national level. There will clearly, however, be a piece of legislation, but what will it resemble? We watch — we wait — we keep informed, and most importantly we remain advocates for patient and physician choice, the voice of physicians in defining care and managing care and universal access to care.

KMA leadership and staff have, in these past months, attempted with the summer seminars a very aggressive program to bring to the membership the current fund of information on our state health system reform legislation, and concurrently presenting a managed care symposium series. I hope you have had the opportunity to participate in these programs, and if so, you clearly will be better prepared to deal with your profession's needs and your patients' needs.

In September, the Annual Meeting of the Kentucky Medical Association will convene, and the House of Delegates will debate on pertinent and timely issues. I encourage you *now* to critically look at issues impacting your county and trustee district, and prepare for the House of Delegates meeting with resolutions and recommendations. I was somewhat discouraged last year with the relative paucity of resolutions, and I urge you now to consider issues not only related to health systems reform but issues in medicine affecting your community, your hospital, and your practice.

Are we truly addressing preventive services in this state? Have we done enough with domestic and interpersonal violence? Have we debated practice guidelines and their utility and implications adequately? And have we addressed the needs of the elderly and the disabled satisfactorily? The issues of workforce planning and education initiatives for physicians have continued to concern many of us and require further evaluation as related to the state of Kentucky. These are timely issues which need discussion and debate and can provide useful guidelines for your leadership as they work on your behalf. Begin your preparation now and add to the body of information and policies currently addressed by the Kentucky Medical Association.

Ardis D. Hoven, MD
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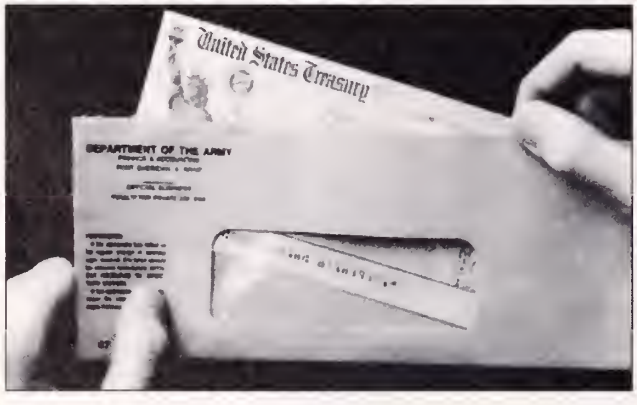
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Carpal Tunnel Syndrome Not Always Work Related

Morton L. Kasdan, MD; Daniel Wolens, MD; Valerie M. Leis, MS; Ann S. Kasdan, RN; Shawn P. Stallings, MS

Carpal tunnel syndrome is all too frequently believed to be strictly a work related disease. A retrospective analysis of 1,884 carpal tunnel patients examined by one hand surgeon between 1977 and 1992 were evaluated for their rate of employment. Twenty-five percent of these CTS patients were not employed at the time their symptoms developed. We conclude that a significant rate of CTS illness exists in the nonemployed population.

Carpal tunnel syndrome (CTS) is a constellation of symptoms involving pain and paraesthesias in the hand, most commonly associated with compression of the median nerve at the wrist. This syndrome was first described by Paget in 1854.[1] It has since also been known as tardy median palsy, median neuritis, and median thenar neuritis.[2] CTS has been associated with metabolic conditions such as diabetes mellitus,[3,4] hypothyroidism,[5,6] rheumatoid arthritis,[7,8] and acromegaly.[9,10] Other situations in which CTS occurs includes obesity,[11] tumors in the carpal canal,[12] pregnancy,[13] and small wrist size.[14] CTS has also been thought to result from work activities involving gripping and repetitive flexion of the wrist.[15-17] It appears today that both nonmedical and medical personnel believe CTS to be predominantly a work related disease.[18-24] This however does not always appear to be true. The purpose of this study is aimed at evaluating the relationship of employment to the development of CTS.

Materials and methods

A retrospective record review was made of 1,884 carpal tunnel syndrome patients that were evaluated from 1977 to 1992 by the senior author in a solo hand surgery practice. This practice has a large occupational referral base. Due to the limitations of history and physical examination in the diagnosis of CTS,[25] only those patients who had symptoms of CTS and nerve conduction studies (NCS) or electromyographic (EMG) findings supportive of CTS were included in the study.[26,27] These individuals were compared to an unmatched control group of non-CTS patients. The control group initially consisted of 500 non-CTS patients randomly chosen from the senior author's practice. Twenty-seven were found to have incomplete record information for purposes of this study and were thus not included. Few inferential statistical comparisons were made between the CTS and control group since the control group was not matched. Employment was defined simply as being gainfully employed at the onset of CTS symptoms. Smoking was defined as having smoked cigarettes or cigars within 15 years of the first office visit. In addition, an attempt was made to evaluate the work relatedness of CTS with work relatedness having been defined by the senior author based on the patient's history of work related stress to include repetitive trauma, forcible gripping, and the use of vibratory tools. Nonwork related activities that could predispose one to CTS, such as hobbies, were not evaluated.

Results

Table 1 provides the descriptive statistics for the carpal tunnel and control group. The CTS group consisted primarily of women (55.6%). There was no difference in hand dominance between the CTS and control groups. Only 1,416 of the 1,884 CTS patients were employed. This rate of employment is significantly less than the rate of employment for the control group ($p = .002$). The rate of smoking was similar for both groups ($p = .58$). Only 48% of the CTS illnesses were determined

Dr Kasdan is a Clinical Professar of Surgery at the University of Louisville and in the Department of Preventive Medicine and Enviranmental Health, University of Kentucky; Dr Walens is Assistant Clinical Professar, Department of Preventive Medicine and Enviranmental Health, University of Kentucky, and a Clinical Instructar in the Department of Family Practice, University of Louisville; Ms Leis and Mr Stallings are medical students at the University of Louisville; and Ms Kasdan is a staff nurse in Dr Kasdan's office.

This project was partially supparted by a grant fram the Arthritis and Orthapedic Center of Excellence at Humana Haspital Suburban, Louisville, KY.

Table 1. Statistics for CTS and cantral graups.

	Carpal Tunnel Synd	Controls	Statistics
Total Patients	1884	473	
Females	1048 (55.6%)	192 (40.6%)	
Males	836 (44.4%)	281 (59.4%)	
Avg Age Females	49	44	
Avg Age Males	44	40	
Right Hand Dam	1728 (91.7%)	433 (91.5%)	(p = .89)
Left Hand Dam	148 (7.9%)	40 (8.5%)	(p = .67)
Ambidextraus	8 (7.9%)	0 (0.0%)	(p = .17)
Right CTS	479		
Left CTS	151		
Bilateral CTS	1254		
Emplayed	1416 (75.2%)	387 (81.8%)	(p = .002)
Wark Related	908 (48.2%)	240 (50.7%)	
Smakers	818 (43.4%)	212 (44.8%)	(p = .58)

to be related to work induced physical stress. However, this is subject to potential bias as its determination was again subjectively made by the examining physician according to the patient's history at the time of examination.

Discussion

A retrospective analysis was completed on 1,884 CTS patients and compared to the non-CTS injuries and illness of an unmatched control group. These patients were evaluated by a single hand surgeon with an active occupational referral base. Due to this large occupational referral base, it would be expected that a large percentage of CTS disease would be associated with work. However, 52% of this population was felt to have nonwork related disease while 25% were not even employed. It is doubtful that the rate of employment was confounded by job loss secondary to CTS. Workmans' compensation laws would have limited this occurrence.

Cumulative trauma disorders are often believed to involve primarily the working or dominant hand. Though work relatedness and hand dominance were not analyzed in this study, it is interesting to note that 1,254, or 67%, of the CTS patients had bilateral disease.

Conclusion

The primary purpose of this study was to evaluate the relationship of work to the development of CTS. Despite some difficulties encountered in study design, it is descriptively significant that of this group of CTS patients, 25% were not employed and 52% were determined to have nonwork related disease. Therefore, CTS is a disease which occurs with significant frequency in those individuals not subject to known repetitive or cumulative trauma. Successful treatment of CTS will thus be dependent upon the search for and treatment of factors that are not directly related to a person's work.

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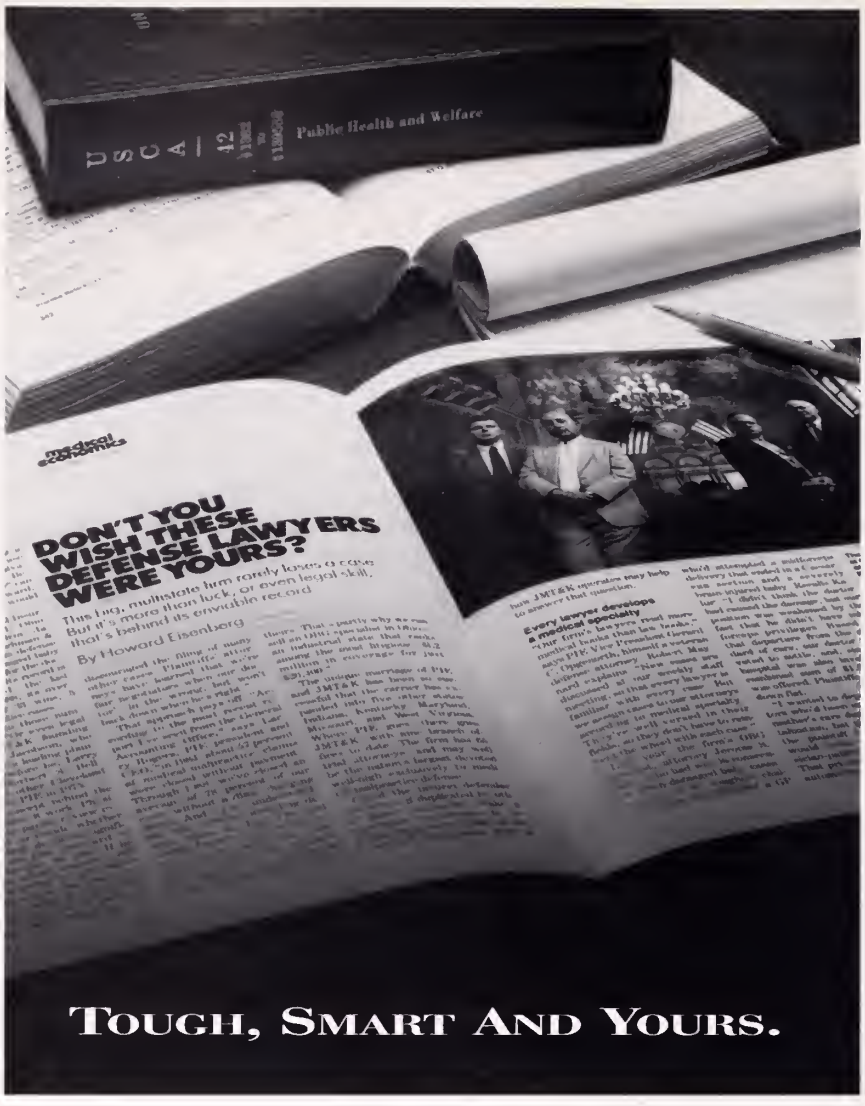
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By Hot Springs the income had ceased even to twitch and the organization was agonal. While Wisconsin and Louisiana argued about the route to revival, Arkansas went to work.

By Biloxi the disintegration continued to dishearten, but Arkansas' David Wroten refused to give up and led the group to close its expensive office operation and persuade the member journals to participate in an informal bankruptcy.

Oklahoma's Mike Sulzycki and Arkansas' David Wroten have been able to persuade the Kincaids of Kansas to undertake the national sales representation for the member journals. The 1994 meeting was held in May at Las Vegas. The reorganization of which I spoke to you in December 1992 was completed, milestones of which were to extract the last of the physicians from the leadership and to adopt a new name for the group.

The member journals' continuation depends on the State Medical Publishers Network and this initial glint of optimism is a relief to us. Please support us with your influence on all actual and potential advertisers.

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Editor

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Fall Board and Conference



Joyce Clark

Across the state children are preparing to return to school and will be spending many hours away from home. They will be placed in the situation of having to make independent decisions regarding their health and safety. Have we prepared them for making these decisions? Is your child strong enough to withstand the pressures of their peers? Do they know where to go for help if help is needed? These are a few of the questions that we will be addressing at the workshops being held at Fall Board.

On September 19 & 20, the KMA Alliance will hold their annual Fall Board Meeting. We will be meeting at the Hyatt Regency Hotel in Louisville. Our meeting will be in conjunction with KMA Convention. Please mark your calendars and plan to attend. If you are a nurse, social worker, teacher, parent, grandparent, or any interested party, we encourage you to attend our meetings and workshops. Workshops on Tuesday have been approved for CE credits.

On Monday our luncheon guest speaker will be Barbara Tippins, the President of AMA Alliance. We are very honored to have her as our guest for Fall Board. There will be workshops on membership, motivating volunteers, and legislation. On Monday afternoon, the workshop on "Motivating Volunteers" will be conducted by Mr Gordon Parker from the National Kidney Foundation. Mr Parker has many years of experience working with volunteers. The Legislative Workshop will be conducted by a representative from AMPAC. Following these workshops all participants are encouraged to attend the KEMPAC Banquet.

On Tuesday we will be honored to have Dr Clifford Kuhn as our luncheon speaker. Dr Kuhn, "The Laugh Doctor," is professor of psychiatry at the University of Louisville School of Medicine, where he is the former associate chairman of the Department of Psychiatry and Behavioral Sciences and director of Attitudinal and Behavioral Medicine. He is an author and lecturer who will add humor to our meeting.

Each community is faced with problems involving youth and violence. Many of these youngsters have been involved in some form of violence such as drug-related violence, sexual violence, or weapon related. If some type of intervention had been in place many of these youngsters may never have been involved in these violence-related problems. In order to be effective in the intervention of these problems, we must first be educated about these problems. We must understand why children are at risk. We need to know how to intervene and help. Come to our workshop on youth and violence, recognizing the at risk child, and intervention. This workshop will be conducted by Mr Charles Fox. Mr Fox, a family services worker for the Department of Social Services, has provided direct services to families, agencies, and the court system, and has developed several treatment modalities and educational groups designed to serve adolescents and families. He received the first National Direct Services Worker Award for his work with adolescents. He is certified by the International Institute for Study and Treatment of Child and Adolescent Sex Offenders at the University of Louisville.

As we continue our efforts to impact the many problems facing our youth today, we hope you will find some intervention means that will be useful in your individual communities. These workshops, our Board Meeting, and luncheons are all open meetings and every physician spouse is encouraged to attend.

For a detailed schedule of our Fall Meeting please turn the page.

Joyce Clark

KMA Alliance President

KMA ALLIANCE
FALL BOARD AND CONFERENCE
SEPTEMBER 19 & 20

MONDAY, SEPTEMBER 19

8 AM–12 NOON Registration
9 AM–12 NOON Committee Meetings
12–1:30 PM Luncheon — Johnnie Amonette, AMA Alliance Field Director for Kentucky — Speaker
2 PM–3 PM Membership — "Idea Fair"
3 PM–4 PM "Motivating Volunteers" — Gordon Parker
4 PM–5 PM Legislation — Neal Rhodes, AMA Washington Office
6 PM KEMPAC Banquet

TUESDAY, SEPTEMBER 20

8 AM–12 NOON Registration
9 AM–12 NOON Board Meeting
12:30–2 PM Luncheon — Dr Clifford Kuhn, ("The Laugh Doctor")
2 PM–5 PM Youth & Violence Workshop — Mr Charles Fox
3 hours of CME credits offered

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KMA ALLIANCE

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SEPTEMBER 20, 1994

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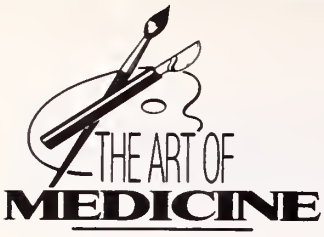
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PRELIMINARY PROGRAM



THE ART OF MEDICINE

KMA Annual Meeting
Sept 19-22 · Hyatt Regency
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**For your convenience these pages are in a special pull-out section.*

Official Call
KMA Annual Meeting

To the officers and members of the component and county medical societies of the KMA.

Meeting Place

The Annual Meeting of KMA will convene on Tuesday, Wednesday, and Thursday, September 20, 21, & 22, at the Hyatt Regency Hotel and Commonwealth Convention Center, Louisville. The first General Session will be called to order at 8:30 AM, Tuesday.

The House of Delegates

The first regular meeting of the House of Delegates will convene at 9:00 AM, Monday, September 19, in the Regency Ballroom, located in the Hyatt Hotel. The second regular business meeting will begin at 7:00 PM, Wednesday, September 21, in the Regency Ballroom.

Registration

The Registration Desk, located outside the Regency Ballroom, 2nd Floor of the Hyatt Regency Hotel, will be open for Delegates at 7:30 AM, Monday, September 19, and at 6:00 PM, Wednesday, September 21. General registration will be held from 7:45 AM until 5:00 PM on Tuesday; 7:45 AM to 4:00 PM on Wednesday; and 7:45 AM to 1:00 PM on Thursday, at the General Registration Desk located in the lobby of the Commonwealth Convention Center.

THE ART OF MEDICINE

KMA Officers 1993-94



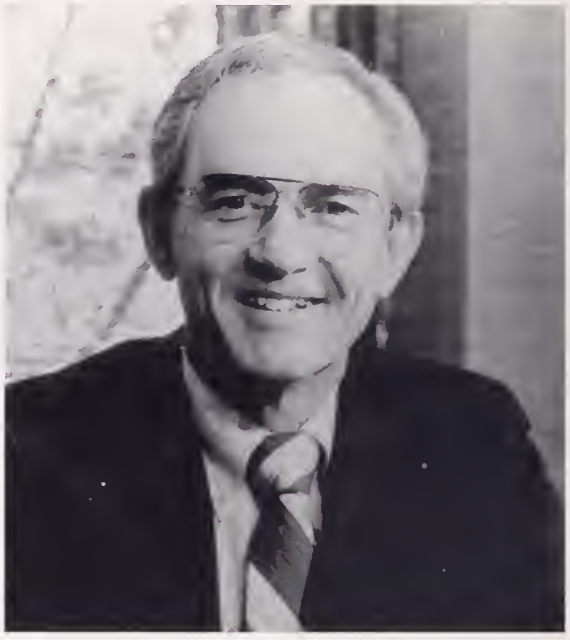
Ardis D. Hoven, MD
KMA President

On September 21, Ardis D. Hoven, MD, Lexington, will pass the mantle of leadership of the Kentucky Medical Association to Robert R. Goodin, MD, Louisville.

Dr Hoven has been dedicated and effective in her contributions to KMA through extensive service. Membership on numerous committees and serving as chair of several have established Dr Hoven as a very knowledgeable member of the Board of Trustees, the first woman ever to be elected to the KMA Board. Dr Hoven currently serves on numerous KMA committees and is an AMA Delegate. Since 1992 she has served on the AMA Advisory Committee on Group Practice. In 1991, she was recipient of KMA's Educational Achievement Award.

A native of Cincinnati, Ohio, Dr Hoven received an MD from the University of Kentucky in 1970. Postgraduate training was accomplished at the University of North Carolina-Chapel Hill.

The first woman to ever hold the office of KMA President, Dr Hoven has provided strong and dedicated leadership during a very challenging year for physicians. Her unflagging performance, her in-depth knowledge of the medical environment, and her ability to articulate this knowledge have made her an exemplary President. KMA recognizes and appreciates the many contributions of this pioneering physician.



Robert R. Goodin, MD
President-Elect

Robert R. Goodin, MD, Louisville, will be installed as President of the Kentucky Medical Association at the President's Luncheon on Wednesday, September 21.

A highly respected cardiologist, Dr Goodin has been dedicated in his nurturance of organized medicine. He is a past President of the Jefferson County Medical Society (1981-82); KMA Alternate Delegate to the AMA House of Delegates (1986-1990); and has served as an AMA Delegate since 1991. He has chaired several KMA committees including Changing Trends in Medicine and Faculty Practice, and currently chairs the Physician Manpower and Economic Entity Feasibility Study Committees. He is a member of the Scientific Program, CME, Legislative Quick Action, and PLI Committees. In 1992 Dr Goodin became a member of the AMA Continuing Medical Education Advisory Committee.

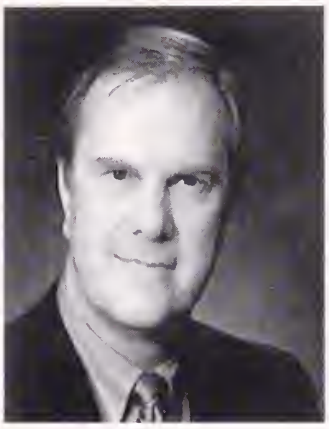
A native of Adair County and a University of Kentucky graduate, Dr Goodin earned his medical degree from the University of Louisville Medical School, where he was senior class president and valedictorian.

Following an internship and residency at Barnes Hospital, Washington University in St. Louis, Dr Goodin earned a cardiology fellowship at Emory University, 1968-70. He served on the faculty of the U of L Medical School from 1970-74 and continues service there as a clinical professor of medicine. In 1974 he began private practice with Cardiovascular Associates in Louisville.



Vice-President
William H. Mitchell, MD
Richmond

Dr Mitchell, a surgeon practicing in Richmond, served KMA as Delegate from 1981-87; 11th District Alternate Trustee from 1981-87; and 11th District Trustee 1988-93. He is a member of the Physician Manpower, Professional Liability Insurance, and Pro Advisory Committees. Dr Mitchell, a 1970 graduate of the University of Kentucky College of Medicine, is immediate past president of the Kentucky Chapter American College of Surgeons, the Hiram C. Polk Surgical Society, and the Madison County Medical Society. He is a member of the American Society of Gastrointestinal Endoscopy, American College of Surgeons, and Johns Hopkins Medical and Surgical Association.



Secretary-Treasurer
William P. VonderHaar, MD
Louisville

A family practitioner, Dr VonderHaar has served on the Interspecialty Council, Professional Education Committee, and as a Delegate for Jefferson County for several terms. He currently serves on the Legislative Quick Action, Continuing Medical Education, and Professional Liability Insurance Committees. He is a charter fellow of the American College of Family Physicians and a member of the American Academy of Family Physicians. A recipient of KMA's Educational Achievement Award in 1988, Dr VonderHaar is a 1956 graduate of the University of Louisville School of Medicine.



Speaker of the House
Danny M. Clark, MD
Somerset

Dr Clark is an OB-GYN from Somerset and a 1962 graduate of the University of Cincinnati College of medicine. He served KMA as Delegate from 1974-1980; 12th District Alternate Trustee from 1974-1980; 12th District Trustee from 1980-1986; and Vice Speaker of the House from 1986-1989. Dr Clark is a member of the Committee on Maternal and Child Health and a fellow of the American College of Obstetricians and Gynecologists.



Vice Speaker of the House
C. Kenneth Peters, MD
Louisville

Dr Peters, a family practitioner, has served KMA as KEMPAC chairman, on the State Legislative Committee 16 years, and has been a KMA Delegate 21 years. He is a past president of the Jefferson County Medical Society, a Charter Fellow of the American Academy of Family Practitioners, and a member of the Jefferson County Academy of Family Practitioners. Dr Peters is a 1960 graduate of the University of Louisville School of Medicine.

THE ART OF MEDICINE

KMA Delegates to AMA



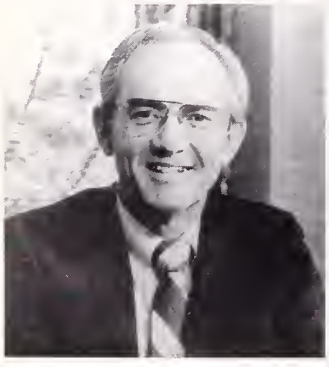
Donald C. Barton, MD
Corbin

Dr Barton, a family practitioner, was elected AMA Delegate in 1984. A past Chairman of the KMA Board of Trustees and past President of the Association, Dr Barton served as KMA Delegate from 1977-79, AMA Alternate Delegate in 1983, and as Vice Chairman, South Eastern Delegation, AMA, in 1993-94. He is past President of the Whitley County Medical Society; past chair of the KEMPAC Board; and was 15th District KMA Trustee from 1978-84. Dr Barton, a 1960 graduate of the University of Louisville School of Medicine, chairs the Committee on National Legislative Activities and serves on the State Legislative Activities Committee. In 1993, Dr Barton received KMA's Distinguished Service Award.



Wally O. Montgomery, MD
Paducoh

Dr Montgomery, a general surgeon, was elected AMA Delegate in 1988. He served KMA as Trustee for several years, as Vice-President, President-Elect, President, Alternate AMA Delegate, KEMPAC Chairman, and on numerous committees. He chairs the State Legislative Committee and Committee on PLI, and is a member of the National Legislative and Awards Committees. A 1962 graduate of the U of L School of Medicine, Dr Montgomery is a past KY Governor and past president of the Kentucky Chapter of the American College of Surgeons and a diplomate of the American Board of Surgery. He is a past recipient of KMA's Distinguished Service Award.



Robert R. Goodin, MD
Louisville

Dr Goodin was elected as AMA Alternate Delegate in 1986 and served consecutive terms until his election as a Delegate in 1990. He has served KMA on numerous committees and currently chairs the Physician Manpower Committee and the Economic Entity Feasibility Study Committee. He is a member of the Scientific Program, CME, Legislative Quick Action, and Professional Liability Insurance Committees. Dr Goodin earned his medical degree in 1964 from the University of Louisville School of Medicine. He is a fellow of the American College of Physicians and the American College of Cardiology.



Ardis D. Hoven, MD
Lexington

Dr Hoven, an infectious disease specialist, was elected AMA Delegate in 1993, following service as an AMA Alternate Delegate from 1989-93; KMA Delegate 1983-88; Vice President 1991-92; President-Elect 1992-93; and current President. She has chaired several and currently serves on numerous KMA committees, and since 1992 has served on the AMA Advisory Committee on Group Practice. A 1970 graduate of the University of Kentucky College of Medicine, Dr Hoven was the 1991 recipient of KMA's Educational Achievement Award.

Journal Editors

A. Evan Overstreet, MD, Editor
Louisville

Dr Overstreet served on the Editorial Board for more than 6 years before becoming Editor of *The Journal* in September 1977. An internist, Dr Overstreet is a 1955 graduate of the University of Louisville School of Medicine. He is a member of the American Society of Internal Medicine, the American College of Physicians, the Transylvania Medical Society, and former President of the Louisville Society of Internists.

Daniel W. Varga, MD
Louisville

Dr Varga, an internist, joined *The Journal* in 1990 as Scientific Editor. A 1984 graduate of the University of Louisville School of Medicine, Dr Varga has served as an Alternate Delegate and a Delegate to the KMA House of Delegates. He is a diplomate of the American Board of Internal Medicine and a member of the American Association for the Advancement of Science, American College of Physicians, and the Southern Medical Association.

Stephen Z. Smith, MD
Louisville

Dr Smith has served as Assistant Scientific Editor for *The Journal* since 1977. He also serves as book review author. A dermatologist, Dr Smith is a 1971 graduate of Johns Hopkins University School of Medicine. He is a member of the KMA Claims and Utilization Review Committee, the American Academy of Dermatology, and the American Medical Association.

Milton F. Miller, MD
Louisville

Dr Miller is Associate Clinical Professor of Medicine at the University of Louisville School of Medicine. An internist, Dr Miller has served as Assistant Editor of *The Journal* since 1976, has been active in the Jefferson County Medical Society, and is a former President of the medical staff at Methodist Evangelical Hospital. He is a 1954 graduate of the University of Louisville School of Medicine.

Martha Keeney Heyburn, MD
Louisville

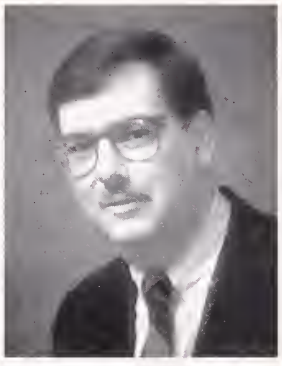
Dr Heyburn joined *The Journal* in 1986 as an Assistant Editor. An ophthalmologist, Dr Heyburn is a 1980 graduate of the University of Louisville School of Medicine. She has served the Jefferson County Medical Society as an Alternate Delegate to KMA, is a member of the American Academy of Ophthalmology, the American Medical Association, and has been a member of KMA since 1981.

Jannice O. Aaron, MD
Louisville

Dr Aaron joined *The Journal* in 1990 as an Assistant Editor. A radiologist, Dr Aaron is a 1977 graduate of the University of Louisville School of Medicine. She served KMA as a Delegate from Adair County in 1985-86 and Jefferson County in 1990. A Past President of the Greater Louisville Radiological Society, she is a member of several professional organizations and a diplomate of the American College of Radiology and the American Society of Neuroradiology.

THE ART OF MEDICINE

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Timothy K. Hulsey, MD
Sixth District





William H. Klompus, MD
Third District





Ronald E. Waldridge, MD
Seventh District





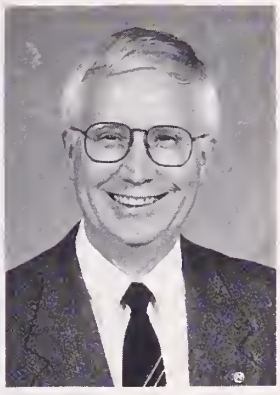
Salem M. George, MD
Fourth District





Mark F. Pelstring, MD
Eighth District





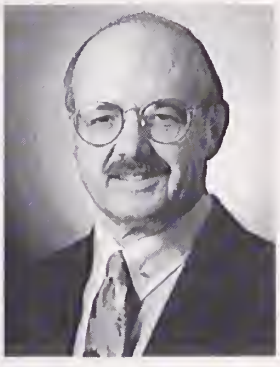
Don R. Stephens, MD
Ninth District





Charles T. Watson, MD
Thirteenth District





Russell L. Travis, MD
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E. D. Roberts, MD
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G. Irene Minor, MD
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Allen
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Breckinridge
Bullitt
Butler
Richard T. Wan, MD, Morgantown
Calloway
R. Gary Marquardt, MD, Murray
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Carlisle
Carroll
Frank F. Palmer, MD, Carrollton
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Paul R. Lewis, MD, Olive Hill
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Howard Gregory Maddux, MD, Marion
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Christopher J. Havelda, MD, Owensboro
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R. Wathen Medley, Jr, MD, Owensboro
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Edmonson
Omkar N. Bhatt, MD, Brownsville
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John A. Patterson, MD, Irvine
Fayette
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James R. Bean, MD, Lexington
John V. Borders, MD, Lexington
John W. Collins, MD, Lexington
W. Lisle Dalton, MD, Lexington
Elvis S. Donaldson, Jr, MD, Lexington
Richard D. Floyd, IV, MD, Lexington
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W. Jeffrey Foxx, MD, Lexington
Bill H. Harris, MD, Lexington
Raleigh O. Jones, MD, Lexington
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John M. Moore, MD, Lexington
William N. Offutt, IV, MD, Lexington
Charles L. Papp, MD, Lexington
Barbara A. Phillips, MD, Lexington
John W. Poundstone, MD, Lexington
Andrew R. Pulito, MD, Lexington
Glenn R. Shearer, MD, Lexington
Thomas K. Slabaugh, MD, Lexington
David B. Stevens, MD, Lexington
John D. Stewart, MD, Lexington
John Robert White, MD, Lexington
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Gallatin
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Patricia Elliott, MD, Mayfield
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Ray A. Cave, MD, Leitchfield
Green
Harry B. Huntsman, MD, Greensburg
Greenup
Manuel Garcia, MD, Ashland
John O. Jones, MD, Flatwoods
Hancock
Hardin-Larue
Vivian H. Bland, MD, Elizabethtown
David Dao, MD, Elizabethtown
Amarjit M. Desai, MD, Elizabethtown
Lucian Yann Moreman, II, MD, Elizabethtown
Jeffrey B. Richardson, MD, Elizabethtown
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F. Andrew Morfesis, MD, Harlan
Kenneth W. Smith, MD, Harlan
Harrison
Donald R. Stephens, MD, Cynthiana
Hart
Clem E. Nichols, MD, Munfordville
Henderson
John S. Cave, MD, Henderson
Marcia L. Cave, MD, Henderson
Frank K. Sewell, Jr, MD, Henderson
Henry-Oldham-Shelby-Spencer
Thomas C. Crain, MD, Taylorsville
Harold F. Funke, MD, Crestwood
William H. Hanking, MD, Shelbyville
David W. Wallace, MD, Shelbyville
Hickman
Bruce C. Smith, MD, Clinton
Hopkins
Wallace R. Alexander, MD, Madisonville
James M. Bowles, MD, Madisonville
Uday Dave, MD, Madisonville
Mohan K. Rao, MD, Madisonville
Jackson
Jefferson
Jannice O. Aaron, MD, Louisville
David T. Allen, MD, Louisville
Stephanie S. Altobellis, MD, Louisville
Kenneth C. Anderson, MD, Louisville
Joseph C. Banis, Jr, MD, Louisville
Arnold M. Belker, MD, Louisville
Susan M. Berberich, MD, Louisville
S.J. Bertolone, Jr, MD, Louisville
Charles J. Bisig, Jr, MD, Louisville
David H. Bizot, MD, Louisville
Harold W. Blevins, MD, Louisville
Susan G. Bornstein, MD, Louisville
C. Matthew Brown, MD, Louisville
Gregory L. Brown, MD, Louisville
William C. Buschemeyer, Jr, MD, Louisville
David E. Bybee, MD, Louisville
Peter C. Campbell, MD, Louisville
Donn R. Chatham, MD, Louisville
Gregory J. Ciliberti, MD, Louisville
Stuart P. Cohen, MD, Louisville
J. William Comer, MD, Louisville
Peter M. Conway, MD, Louisville
Warren Cox, IV, MD, Louisville
Frederick Cressman, Jr, MD, Louisville
John H. Doyle, MD, Louisville
Rudy J. Ellis, Jr, MD, Louisville
Samuel G. Eubanks, Jr, MD, Louisville
John M. Farmer, MD, Louisville
Marjorie R. Fitzgerald, MD, Louisville
Robin M. Floyd, MD, Louisville
Darius Ghazi, MD, Louisville
Linda H. Gleis, MD, Louisville
Harold D. Haller, MD, Louisville
B. Thomas Harter, Jr, MD, Louisville
Jayne L. Hollander, MD, Louisville
Clifford V. Jennings, MD, Louisville
John Jurige, Jr, MD, Louisville
Sheri A. Kalbfleisch, MD, Louisville

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Catherine Newton, MD, Louisville
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Steve J. Raible, MD, Louisville
James E. Redmon, MD, Louisville
K. Thomas Reichard, MD, Louisville
William M. Renda, MD, Louisville
Sheryl M. Schneider, MD, Louisville
George Randolph Schrodt, MD, Louisville
George R. Schrodt, Jr, MD, Louisville
Edward L. Scofield, MD, Louisville
Lynn T. Simon, MD, Louisville
Judah L. Skolnick, MD, Louisville
Wm. C. Templeton, III, MD, Louisville
Stuart Urbach, MD, Louisville
Daniel W. Varga, MD, Louisville
Gary C, Vitale, MD, Louisville
Norton G. Waterman, MD, Louisville
David R. Watkins, MD, Louisville
Samuel D. Weakley, MD, Louisville
A. Franklin White, Jr, MD, Louisville
Russell A. Williams, MD, Louisville
C. Milton Young, III, MD, Louisville
Kenneth N. Zegart, MD, Louisville

Jessamine

Johnson

Franklen K. Belhasen, MD, Paintsville

Knott

W. Grady Stumbo, MD, Hindman

Knox

Rogelio A. Acosta, MD, Barbourville

Laurel

David W. Douglas, MD, London

Lawrence

William C. Thorndyke, MD, Louisa

Lee

James B. Noble, MD, Beattyville

Leslie

Roy Varghese, MD, Hyden

Letcher

Van S. Breeding, MD, Whitesburg

Lewis

Lincoln

C. Glen Click, MD, Stanford

Livingston

Stephen Burkhart, MD, Salem

Logan

Patrick K. Hayden, MD, Russellville

Madison

Magoffin

Marion

Richard V. Steeves, MD, Lebanon

Marshall

Martin

Mason

McCracken

W. Winston Barnard, MD, Paducah
James R. Gould, MD, Paducah
John E. Grubbs, MD, Paducah
Peter E. Locken, MD, Paducah
John D. Noonan, MD, Paducah
Allen L. Tinsley, MD, Paducah
Ronald L. Wilson, MD, Paducah

McCreary

McLean

Meade

Menifee

Mercer

George W. Noe, MD, Harrodsburg

Metcalfe

Monroe

James E. Carter, MD, Tompkinsville

Montgomery

Morgan

George R. Bellamy, MD, West Liberty

Muhlenberg

William L. Miller, MD, Greenville

Nelson

Nicholas

Northern Kentucky

Gordon W. Air, MD, Crestview Hills
Robert L. Baker, Jr, MD, Crescent Springs
Elbert D. Baldridge, Jr, MD, Covington
Thomas E. Bunnell, MD, Erlanger
Mark A. Cepela, MD, Edgewood
James Evans, III, MD, Fort Thomas
Joseph C. Martin, MD, Erlanger
Ross McHenry, MD, Covington
George E. Miller, MD, Crescent Springs
Theodore H. Miller, MD, Edgewood
Michelle M. Murray, MD, Alexandria
Michael L. Robinson, MD, Edgewood
Marguerite S. Schabell, MD, Florence
B. Robert Schwartz, MD, Edgewood
Steven M. Woodruff, MD, Florence

Ohio

Owen

Owsley

Pendleton

Robert L. McKenney, MD, Falmouth

Pennyrile

Perry

Gilroy L. Daley, MD, Hazard
Mitchell Wicker, Jr, MD, Hazard

Pike

Powell

Pulaski

Donald E. Brown, MD, Somerset
James D. Crase, MD, Somerset
Joseph G. Weigel, MD, Somerset

Robertson

Rockcastle

William D. Dooley, MD, Mount Vernon

Rowan

Russell

H. Michael Oghia, MD, Russell Springs

Scott

Simpson

Michael Pulliam, MD, Franklin

Taylor

Eugene H. Shively, MD, Campbellsville

Trimble

Roderick H. MacGregor, MD, Bedford

Union

Wallas N. Bell, MD, Morganfield

Warren

James F. Beattie, Jr, MD, Bowling Green
John T. Burch, MD, Bowling Green
Joe T. Davis, MD, Bowling Green
Robert J. Emslie, MD, Bowling Green

Washington

Charles D. Howard, MD, Springfield

Wayne

James K. Phillips, Jr, MD, Monticello

Webster

Whitley

Wolfe

Paul F. Maddox, MD, Campton

Woodford

C. Dale Goodin, MD, Versailles

KMA Hospital Medical Staff Section

William D. Pratt, MD, London

KMA Resident Physicians Section

Donna Marlowe Skinker, MD, Lexington

KMA Student Section

LeAnn Simmons, UK, Lexington
Andrea Faulconer, UL, Louisville

THE ART OF MEDICINE

Elections

Nominating Committee to Meet Monday, September 19

The KMA Nominating Committee will hold an open meeting at the close of the first meeting of the House of Delegates, Monday, September 19, in the Regency Ballroom at the Hyatt Regency Hotel. Any KMA member may confer with the Committee during this meeting.

The report of the Nominating Committee will be posted in the general assembly hall at the conclusion of the first general session, Tuesday morning, September 20.

Nominations may be made from the floor during the second meeting of the House of Delegates, Wednesday evening, September 21, in the Regency Ballroom. The House will vote on the nominees at this meeting.

Members of this Committee are: James E. Redmon, MD, Louisville, Chair; Donald E. Brown, MD, Somerset; W. Lisle Dalton, MD, Lexington; Stephanie R. Hatfield, MD, Paducah; and Susan H. Prasher, MD, Ashland.

Nominations should be sent before the Annual Meeting to the KMA Headquarters Office, Attention, Nominating Committee.

House to Elect New Officers During Annual Meeting

KMA officers for the 1994-95 Association year will be elected by the House of Delegates at the close of its final meeting, Wednesday evening, September 21. Officers to be elected from the state-at-large are:

Office	Year
President-Elect	1 Year
Vice President	1 Year
Delegates to AMA	2 Years
*Wally O. Montgomery, MD Paducah	
*Robert R. Goodin, MD Louisville	
New Position	
Alternate Delegates to the AMA	2 Years
*Bob M. DeWeese, MD Louisville	
*Preston P. Nunnelley, MD Lexington	
New Position	

*Incumbent

Election of Trustees and Alternate Trustees

The House of Delegates will elect five District Trustees and five Alternate Trustees at its second regular meeting, Wednesday, September 21. Nominations will be made by the Delegates from the electing Districts, at a meeting following the first meeting of the House on Monday, September 19.

The Nominating Committee will report at the close of the first scientific session on Tuesday, September 20. Further nominations may be made from the floor at the final meeting of the House on Wednesday evening, September 21. All nominations are considered and acted upon by the Delegates at this final meeting.

Districts electing Trustees for 3-year terms are: 2nd District (incumbent, John W. McClellan, MD, Henderson); 7th District (incumbent, Ronald E. Waldridge, MD, Shelbyville); 9th District (incumbent, Donald R. Stephens, MD, Cynthiana); 10th District (incumbent, Russell L. Travis, MD, Lexington); and 13th District (incumbent, Charles T. Watson, MD, Ashland).

Trustees in the 7th, 9th, and 10th Districts are eligible for reelection, while the Trustees in the 2nd and 13th Districts have served two consecutive terms and are not eligible for reelection.

Districts electing Alternate Trustees are the same as those electing Trustees. Incumbents are: 2nd District, Christopher R. McCoy, MD, Owensboro; 9th District, Robert L. McKenney, MD, Falmouth; 10th District, Gary R. Wallace, MD, Lexington; and 13th District, Bruce M. Stapleton, MD, Ashland. Alternate Trustees in the 9th and 10th Districts are eligible for reelection; those in the 2nd and 13th Districts are not eligible.

In addition, there is a vacancy in the 7th District, and an Alternate needs to be elected for a full 3-year term.

Reference Committee Activity

Speakers Danny M. Clark, MD, Somerset, and C. Kenneth Peters, MD, Louisville, will assign all officers' and committees reports and Resolutions to one of five Reference Committees at the first meeting of the KMA House of Delegates at 9:00 A.M. Monday, September 19. A brief session for Reference Committee Chairmen will be held at 11:00 A.M. Monday in the Derby Suite, located in the Hyatt Hotel. Any KMA member wishing to testify on any Resolution or report is urged to be present for the Reference Committee meetings which will be held at noon Monday, September 19, on the first floor of the Hyatt Hotel. These open sessions will last at least one hour in order for all who wish to speak to be heard. Following the open hearings, the Committees will go into executive sessions to study the reports, review the testimony, and write their reports to the House.

The Committees' recommendations will be presented at the final meeting of the House, Wednesday evening, September 21, in the Regency Ballroom, Hyatt Hotel.

Appointments to Reference Committees and Credentials Committee and Tellers are now being finalized by the Speakers.

If your society has not yet submitted the name of your Delegate(s) to the Headquarters Office, you should do so immediately, as only those names recorded in the office can be considered for appointment to one of the Reference Committees and be listed as official county representatives.

A complete listing of members who will be serving on the five Reference Committees and the location of the Reference Committee meetings will be published in the September issue of the KMA *Journal*.

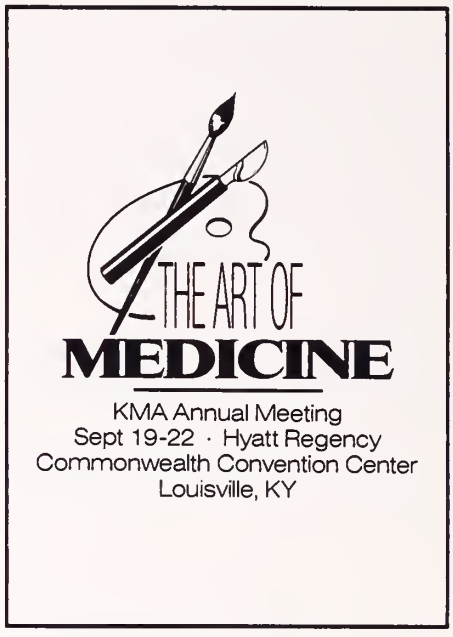
Anyone desiring names of Reference Committee members before the September issue is published should contact the Headquarters Office.

Make Your Reservations Now

It is important that you begin to make your room reservations as soon as possible for the KMA Annual Meeting, September 19-22. The Hyatt Regency Louisville will be the Headquarters Hotel (Phone 502/587-3434). In making your reservations, remember the first House of Delegates meeting will be Monday, September 19. Be sure and identify yourself as a KMA meeting attendee to receive the special convention rate — Single — $75/Double — $85.

THE ART OF MEDICINE

Annual Meeting Special Features



1994 Annual Meeting Honors Past President James W. Ellis, MD

The 1994 Annual Meeting of the Kentucky Medical Association will be officially titled "The James Wesley Ellis Meeting" in remembrance of the 1914 President of the Association. The tradition of honoring a past president of KMA and other distinguished physicians originated with the 1935 Annual Meeting. Eugene H. Conner, MD, Louisville, KMA Historian, has written a biography on Dr Ellis that begins on page 325.

Scientific Sessions are scheduled for September 20 and 21 at the Commonwealth Convention Center in Louisville. The theme for the 1994 scientific session is "The Art of Medicine." Both the presentations and discussion periods will contribute to the continuing medical education of Kentucky's physicians.

Twenty-three Specialty Groups will hold meetings on September 20, 21 & 22 beginning at 1:30 PM on Tuesday, 2:15 PM on Wednesday, and 9:00 AM on Thursday. Individual programs of specialty societies and meeting locations are listed in this issue. All general sessions will be held in the mornings. Specialty groups will meet all three days with no general sessions scheduled during these specialty group meetings. All KMA members are invited to attend any specialty meetings.

Scientific and Technical Exhibits will display new medical products, services, and techniques in the Exhibit Hall, located in the Commonwealth Convention Center, during the 1994 Annual Meeting. Members and guests are urged to take the opportunity to view products of interest at the 30-minute intermissions scheduled during each general and specialty session.

The KMA House of Delegates will meet twice during the Annual Meeting. The first meeting of the House will be held at 9:00 AM, Monday, September 19, in the Regency Ballroom located in the Hyatt Hotel. The final meeting will be held Wednesday, September 21, at 7:00 PM, also in the Regency Ballroom. Officers for the 1994-95 Associational year will be elected at the second meeting.

The President's Installation & Awards Luncheon will be held on Wednesday, September 21, in the Regency Ballroom located in the Hyatt Hotel. The luncheon will include the presentation of KMA awards and the installation of the 1994-95 President, Robert R. Goodin, MD, Louisville.

KEMPAC



DO YOU NEED A NIGHT TO GET AWAY FROM IT ALL?

HERE IS YOUR OPPORTUNITY TO GET TOGETHER WITH YOUR FELLOW PHYSICIANS AND FRIENDS

THE 32nd ANNUAL KEMPAC SEMINAR-DINNER

IS FAST APPROACHING
MARK YOUR CALENDAR!!

DATE: Monday, September 19, 1994

TIME: 6:00 PM EDT — Reception
7:00 PM EDT — Dinner (Program to follow)

PLACE: Regency Ballroom
Hyatt Regency Hotel
Louisville, Kentucky

KEMPAC

TICKETS WILL BE AVAILABLE VERY SOON! They can be purchased from the KEMPAC Headquarters Office for $30.00 each. Please contact the KEMPAC office at 502/426-6200 or watch the monthly *Communicator* for ticket information.

Medical Office and Clinic Staff Claims Prevention Seminar

Kentucky Medical Insurance Company will offer a special claims prevention seminar for medical office and clinic staff during the KMA Annual Meeting. The 1994 Claims Prevention Seminar and Office Self Assessment was developed specifically for the medical office/clinic staff members. The seminar is a fast-paced program which will discuss and review the office self assessment. The self assessment will be mailed to your office after your registration is received. Early registration is essential to allow ample time to complete the self assessment before the seminar.

The cost is $25 per office/clinic staff member employed by physicians insured by Kentucky Medical. For office/clinic staff whose physician employer is not insured by Kentucky Medical, the cost is $35 per person.

The seminar is scheduled from 9:00 to 11:00 am on Wednesday, September 21, 1994, at the Hyatt Regency Hotel, Louisville. In order to register, please call Kentucky Medical Insurance Company at 800/467-1858 or in Louisville, 339-5771, for a registration form.

Physician Seminar Kentucky Medical Insurance Company's Risk Management Seminar

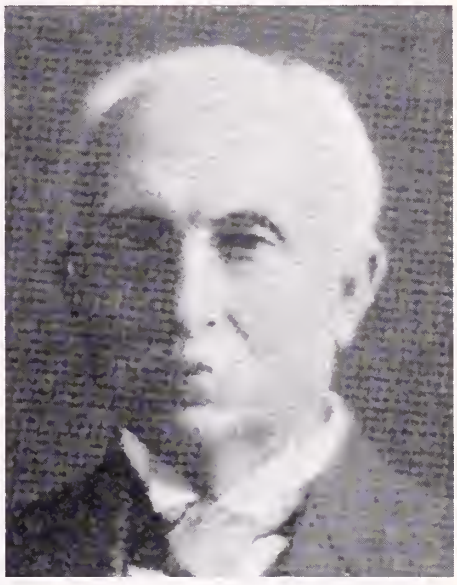
Kentucky Medical Insurance Company will be presenting a two-hour Risk Management Seminar On Physician/Patient Communication during the KMA Annual Meeting. The seminar will be held Thursday, September 22, 1994, at the Hyatt Regency in Louisville. Lunch will be provided from 12:00 noon until 1:00 pm and the seminar will follow at 1:00 pm and conclude at 3:00 pm. The cost of the seminar is $50.00 and is open to all physicians.

Physicians insured with Kentucky Medical Insurance will receive a 5% premium credit on their next policy renewal for their participation.

The Kentucky Medical Insurance Company is accredited by the Kentucky Medical Association to sponsor continuing medical education for physicians. Kentucky Medical Insurance Company designates this activity for two credit hours in Category I of the Physicians Recognition Award of the American Medical Association Continuing Medical Education Credits.

For registration information, call Kentucky Medical Insurance Company toll free at 800/467-1858 or 339-5700. Don't miss this opportunity--register early for this exceptional program.

James Wesley Ellis, MD 1846-1935



The former President of the Kentucky Medical Association whom we memorialize at this Annual Meeting, James Wesley Ellis, MD, was unable to serve in this elected office as a result of failing health and a need for rest; however, it is stated erroneously in *JKMA*, centennial issue of September 1951, that he had died in office.

That he was unable to attend the meeting which would have marked his transition from President-Elect to President in Newport, Kentucky on 22 September 1914, is apparent in that his "President's Address" was presented by his fellow Daviess Countian, Daniel M. Griffith, MD, a Past-President of KMA (1907).[1] Dr Ellis must have regained his health somewhat for he was able to return to his practice and remained on their 325-acre farm for 5 more years.[2] They moved to Owensboro in 1919.

Ellis was born 13 December 1846, near Knottsville, Daviess County, Kentucky, the son of Luther R. Ellis and Mary Kellain Ellis.[3] When he was orphaned at age 6 by the death of his father, he and his elder brother, William S. Ellis, were taken by their mother to the home of their maternal grandfather, the Reverend Hiram Kellain, a Methodist minister. When a young teenager, he left his grandfather's home and went to work on the farm of John Evans at Pleasant Valley, Kentucky, where he could earn his tuition to the Pleasant Valley Seminary. At age 18 years he attended Bacon College in Harrodsburg, Mercer County, Kentucky.

He was able to afford only 2 years at college and returned to his home county to teach school in Whitesville. Here he began the study of medicine under Doctors McKay and C. C. Hale.[4] His preceptorship lasted 15 months. In the Fall of 1868, he enrolled at the Jefferson Medical College in Philadelphia. Taking his second course of lectures during the following term, he received his MD degree there in the spring of 1870.[5]

Upon his return to Daviess County with his medical diploma, he established a practice in the small rural community of Masonville where he practiced for half of a century. On 26 April 1877, he married Miss Elizabeth Ann "Bettie" Whipp. They had born to them a daughter and a son who survived to maturity. Their son, William T. Ellis, became a physician and practiced in Philadelphia, Pennsylvania. Their daughter became the wife of Edward Barr, MD, of Owensboro.

Dr Ellis, a school teacher in his youth, and having experienced difficulty of obtaining an education, throughout his lifetime devoted some of his attention toward the betterment of educational opportunities for the youth of Daviess County. He was instrumental in focusing public attention on education which resulted in increasing the school year from 5 to 9 months, and he successfully campaigned for funds to assure its implementation.

Active in Medical Society affairs, Dr Ellis served as President of the Daviess County Medical Society (1910) as well as The McDowell Medical Society soon after it was founded in 1874. In spite of a busy practice he published two of his addresses, one on "Medical Ethics"[6] which had been presented to his county society at their December 1913 meeting, and the other was his "President's Address." In his "Presi-

dent's Address" he presented two divergent topics: the tragedy of the clash of arms in Europe and the improvement of the health of our citizens by teaching and the diligent application of public health measures. During the early decades of the 20th century, public health measures remained the strongest arm of medicine in controlling the spread and reducing the mortality of disease. During WWI he served as chairman of the National Defense Board in his home county.

Dr and Mrs Ellis were members of the Christian Church and the Doctor was a Mason and a staunch Democrat.

Although no notice of his death has been located in the *Journal of the Kentucky Medical Association*, a brief notice of his death has been located in the *Journal of the American Medical Association*.[7] He died at the home of his daughter and son-in-law, having outlived many of his contemporaries with whom he had labored in our profession.

Eugene H. Conner, MD
KMA Historian

References

1. Ellis JW. President's Address. *JKMA*. 1914;12(1 October):584-587.
2. [Orahood MD] *Doctors in Western Kentucky (1815-1992). Life is Short.* Dorr, Owensboro, KY [1992]. p 70.
3. *Owensboro* [KY] *Inquirer.* Friday, January 4, 1935.
4. Kerr C, Editor. *History of Kentucky* in 5 Volumes. The American Historical Society, Chicago and NY, 1922. *3*, 306.
5. *Catalogue of Graduates of Jefferson Medical College of Philadelphia 1826-1879*, Collins, Philadelphia, 1879. p 19.
6. Ellis JW. Medical Ethics. *JKMA*. 1914;12(1 April):233-234.
7. Deaths. *JAMA*. 1935;104(16 February):582.

Introducing the Annual Meeting Speakers



Michael S. Blaiss, MD
Memphis, TN
Associote Professor of Pediotrics, Assistont Professor of Medicine, Director of Pediotric Allergy/Immunology Troining Progrom, University of Tennessee, Memphis. MD, 1976, University of Tennessee. Post President, Allergy/Immunology Section of Southern Medicol Associotion.



Bruce MacFadyen, Jr, MD
Houston, TX
Professor, Deportment of Surgery, The University of Texos Houston Heolth Science Center; Director of Loser, Endoscopic, ond Loporoscopic Surgery, the University of Texos Medicol School of Houston ond Hermonn Hospitol. MD, 1968, Hohnemonn Medicol College ond Hospitol, Philodelphio.



Andrew T. Pavia, MD
Solt Loke City, UT
Assistont Professor of Pediotrics ond Medicine, University of Utoh Medicol School; Associote Director, University of Utoh Heolth Sciences AIDS Center; Medicol Director, UUMC AIDS Clinic, Solt Loke City. MD, 1981, Brown University, Providence, RI. Cofounder HIV/AIDS Progrom, University of Utoh.



Arthur F. Haney, MD
Durhom, NC
Roy T. Porker Professor of Obstetrics ond Gynecology (Endowed Choir); Director, Division of Reproductive Endocrinology & Infertility; ond Associote, Deportment of Rodiology, Duke University Medicol Center, Durhom. MD, 1972, University of Arizono College of Medicine, Tucson.



Ronald E. Smith, MD
Los Angeles, CA
Professor ond Acting Choirmon, Deportment of Ophtholmology, USC School of Medicine ot the Doheny Eye Institute, Los Angeles. MD, 1967, Johns Hopkins University School of Medicine, Boltimore. President, Americon Acodemy of Ophtholmology.



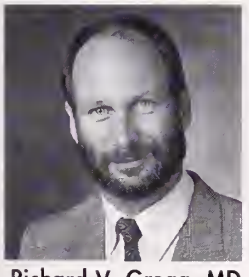
David V. Feliciano, MD
Atlonto, GA
Professor of Surgery, Emory University School of Medicine; Chief of Surgery, Grody Memoriol Hospitol, Atlonto. MD, 1970, Georgetown University School of Medicine, Woshington, DC. Post President, Southwestern Surgicol Congress ond the Western Troumo Associotion.



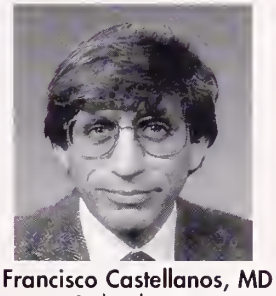
Bernard F. Morrey, MD
Rochester, MN
Professor of Orthopedic Surgery, Moyo Medicol School; Choirmon, Deportment of Orthopedic Surgery, Moyo Foundotion, Rochester. MD, 1971, University of Texos Medicol Bronch, Austin. President, Americon Acodemy of Orthopoedic Surgeons.



Burton V. Reifler, MD
Winston-Solem, NC
Professor ond Choirmon, Deportment of Psychiotry ond Behoviorol Medicine, Bowmon Groy School of Medicine, Winston-Solem. MD, 1969, Emory University School of Medicine, Atlonto. Fellow, Americon Psychiotric Associotion ond Gerontologicol Society of Americo.



Richard V. Gregg, MD
Cincinnoti, OH
Associote Professor, University of Cincinnoti Anesthesio Deportment; Director, University Poin Control Center. MD, 1981, University of Louisville School of Medicine.



Francisco Castellanos, MD
Bethesdo, MD
Senior Stoff Fellow, Child Psychiotry Bronch, Notionol Institute of Mentol Heolth, Bethesdo. MD, 1986, Louisiono Stote University Medicol Center, Shreveport. Fellow, Americon Acodemy of Pediotrics.



Michael I. Vender, MD
Arlington Heights, IL
Hond Surgery Associotes, S.C., Arlington Heights, IL; Instructor of Clinicol Orthopoedic Surgery, Northwestern University Medicol School. MD, 1979, University of Illinois College of Medicine, Chicogo.



Joseph W. Segura, MD
Rochester, MN
Corl Rosen Professor of Urology, Moyo Medicol School, Rochester. MD, 1965, Northwestern University, Chicogo. President-Elect, North Centrol Section of Americon Urologicol Associotion.

THE ART OF MEDICINE



Kenneth E. Salyer, MD
Dollos, TX
Director ond Founding Choirmon, Internotionol Croniofociol Institute ond the Cleft Lip ond Polote Treotment Center, Medicol City Dollos Hospitol; Professor, University of Texos Southwestern Medicol School, Division of Plostic Surgery, Dollos. MD, 1962, University of Konsos School of Medicine.



Peter S. Kussin, MD
Hillsborough, NC
Assistont Professor, Deportment of Medicine, Division of Allergy, Criticol Core ond Respirotory Medicine, Duke University Medicol Center, Durhom. MD, 1985, Mount Sinoi School of Medicine, New York City.



M. Therese Southgate, MD
Chicogo, IL
Senior Contributing Editor, *Journol of the Americon Medicol Associotion*. MD, 1960, Morquette University School of Medicine, Milwoukee.



Donald E. Henson, MD
Bethesdo, MD
Progrom Director, Eorly Detection Bronch, Division of Concer Prevention ond Control, Notionol Concer Institute; Coptoin, US Public Heolth Service, Commissioned Corps, Deportment of Heolth ond Humon Services. MD, 1962, St. Louis University School of Medicine.



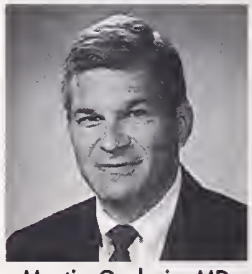
Warren Piette, MD
Iowo City, IA
Professor, Deportment of Dermotology, University of Iowo College of Medicine. MD, 1975, University of Texos Southwestern Medicol School, Dollos.



Paul M. Wax, MD
Rochester, NY
Assistont Professor, Emergency Medicine, University of Rochester School of Medicine; Assistont Director, Finger Lokes Poison Control Center, Rochester. MD, 1984, Mount Sinoi School of Medicine, New York.



Kenneth H. Richmond, MD
Louisville, KY
Privote proctice in ototoryngology. MD, 1981, Columbio College of Physicions & Surgeons, New York.



Martin Grabois, MD
Houston, TX
Professor ond Choirmon, Physicol Medicine ond Rehobilitotion; Professor of Clinicol Anesthesiology ond Restorotive Neurology ond Humon Neurobiology, Boylor College of Medicine, Houston. MD, 1966, Temple University School of Medicine, Philodelphio. President-Elect, Americon Acodemy of Physicol Medicine ond Rehobilitotion; ond President, Internotionol Rehobilitotion Medicine Associotion.

(Photo not ovoiloble)

George T. Tindall, MD
Atlonto, GA
Professor ond Choirmon, Deportment of Neurosurgery, Emory University School of Medicine, Atlonto. MD, 1952, Johns Hopkins University School of Medicine. Post President, Americon Associotion of Neurologicol Surgeons, Congress of Neurologicol Surgeons, ond Southen Neurologicol Society.

THE ART OF MEDICINE

Kentucky Medical Association

Scientific Program

J. W. Ellis Meeting

Ardis D. Hoven, MD
KMA President, Presiding

Tuesday, September 20, 1994
General Sessions Area —
Commonwealth Convention Center

8:30 AM Opening Ceremonies
8:40 AM **"Everything You Wanted To Know About Graves' Disease"**
David V. Feliciano, MD, FACS, Atlanta, GA
9:00 AM **"Women in the Perimenopausal Transition"**
Arthur F. Haney, MD, Durham, NC
9:20 AM **"What To Do With the Recurrent Stone Former"**
Joseph W. Segura, MD, Rochester, MN
9:40 AM **"New Technology in Neurosurgery"**
George Tindall, MD, Atlanta, GA
10:00 AM **Intermission to visit exhibits**
10:30 AM **"Advances in the Art of Ophthalmology"**
Ronald E. Smith, MD, Los Angeles, CA
10:50 AM **"The Art and Science of Craniofacial Surgery"**
Kenneth E. Salyer, MD, Dallas, TX
11:10 AM **"Asthma: State of the Art"**
Peter S. Kussin, MD, Durham, NC
11:30 AM **"New Concepts in Total Hip Arthroplasty"**
Bernard F. Morrey, MD, Rochester, MN

Ky Chapter, American College of Surgeons

General Sessions Area —
Commonwealth Convention Center
Tuesday, September 20, 1994

1:30 PM **"Operative Management of Splenic and Hepatic Injuries"**
David V. Feliciano, MD, FACS, Atlanta, GA
2:15 PM **"Managed Care in Trauma Management"**
William O. Massie, Lexington, KY
2:30 PM **"Cost Containment in the ICU"**
Paul A. Kearney, MD, FACS, Lexington, KY
2:45 PM **"Developing Trauma Systems in Kentucky"**
Robert Calhoun, MPH, Frankfort, KY
3:00 PM **Panel Discussion: "Trauma Care — Managing Care in the 1990s"**
Panelists: Calhoun, Feliciano, Kearney, Massie, Mitchell
3:30 PM **"Management of Carcinoma In-situ of the Breast"**
Patrick C. McGrath, MD, FACS, Lexington, KY
3:45 PM **"Operative Therapy for Hepatic Tumors"**
Michael J. Edwards, MD, FACS, Louisville, KY
4:00 PM **"Pancreatic Cancer — Update 1994"**
William E. Strodel, III, MD, FACS, Lexington, KY
4:15 PM **"Surgical Management of Inflammatory Bowel Disease"**
Wayne Tuckson, MD, Louisville, KY
4:30 PM **"Strategies for Enteral Nutrition Access"**
Thomas N. Zweng, MD, FACS, Lexington, KY
4:45 PM **"Symptomatic Abdominal Aortic Aneurysms: Does Preoperative Management Improve Outcome"**
Michael J. Buckmaster, MD, Lexington, KY
Thomas H. Schwarcz, MD, FACS, Lexington, KY
5:00 PM **"Changing Trends in Surgical Education"**
Richard W. Schwartz, MD, FACS, Lexington, KY
5:15 PM Adjournment



KMA Medical Student Section & KMA Resident Physician Section

Meeting Room 105 — Lower Level — Commonwealth Convention Center
Tuesday, September 20, 1994

1:00 PM **Opening and Welcome**
KMA-RPS Chair
Presidents — UL/UK Chapters, KMA-MSS
1:15 PM **"Art in Medicine" slide presentation**
Jim VanHoose, MD, UK Resident
1:25 PM **"Workforce Planning — The Future of Medicine"**
Student Perspective —
Representative, AMA-MSS
Resident Perspective —
Judy Linger, MD, AMA-RPS
Practicing Physician Perspective —
Robert R. Goodin, MD, Chair, KMA Physician Manpower Committee
2:10 PM **Question and Answer Session**
2:25 PM **"The Art of Medicine — Impact on the Image of Physicians"**
Ronald Waldridge, MD, Family Physician, Shelbyville, KY

Ky Neurosurgical Society

Meeting Room 109 — Lower Level — Commonwealth Convention Center
Tuesday, September 20, 1994

1:00 PM **"Management of Hypersecreting Pituitary Tumors"**
George T. Tindall, MD, Atlanta, GA
2:00 PM **"Pituitary Apoplexy: Clinical Presentation and Management"**
John J. Guarnaschelli, MD, Louisville, KY; David A. Petruska, MD, Louisville, KY; Jeff Florman, MD
2:15 PM **"Interventional Neuroangiography by Neurosurgery"**
Jonathan E. Hodes, MD, Lexington, KY
2:30 PM **Intermission to visit exhibits**
2:45 PM **"Unusual Causes of Spinal Cord Tethering"**
Benjamin C. Warf, MD, Lexington, KY
3:00 PM **"Radiosurgery with the LINAC Scalpel"**
Christopher B. Shields, MD; Tim Guan, MD; Peter Allmond, MD; Robert Lindberg, MD; Karen Shields, MD
3:15 PM **"Concepts in Recurrent Malignant Glioma"**
Peter Gianaris, MD
3:30 PM **"What's New in CNS Transplantation?"**
Dante J. Morassutti, MD
3:45 PM **"Management of Brainstem Tumors in Children"**
Andrew Reisner, MD
4:00 PM **"The Neurosurgical Response to Managed Care"**
James R. Bean, MD, Lexington, KY
4:30 PM **"Federal Health Care Reform in Neurosurgery"**
Russell L. Travis, MD, Lexington, KY
5:00 PM Business Meeting
6:00 PM Dinner

Ky Academy of Eye Physicians and Surgeons

Meeting Room 108 — Lower Level — Commonwealth Convention Center
Tuesday, September 20, 1994

1:30 PM **"Cataract Extraction in Uveitis"**
Ronald E. Smith, MD, Los Angeles, CA
2:00 PM **"Prohibitions on Medicare & Medicaid Referrals"**
William E. Doll, Attorney, Jackson & Kelly
2:30 PM **"Current Issues within the American Academy of Ophthalmology"**
Ronald E. Smith, MD, Los Angeles, CA
3:00 PM **Intermission to visit exhibits**
3:30 PM **"Office Management of Common Lid Margin Disorders"**
Ronald E. Smith, MD, Los Angeles, CA
4:00 PM Business Meeting
5:00 PM Reception — Regency South Ballroom A
6:30 PM Adjournment

Ky Urological Association

Meeting Room 107 — Lower Level — Commonwealth Convention Center
Tuesday, September 20, 1994

1:30 PM **"Endopyelotomy for Uretero Pelvic Junction Obstruction: Technique and Results"**
Joseph W. Segura, MD, Rochester, MN
2:30 PM **Intermission to visit exhibits**
3:00 PM Pyelogram Hour
4:00 PM Business Meeting
5:00 PM Adjournment
7:00 PM Dinner at the Jefferson Club

Ky Society for Plastic & Reconstructive Surgeons

Meeting Room 111 — Lower Level — Commonwealth Convention Center
Tuesday, September 20, 1994

1:30 PM **"Chemical Peel: A Historical Perspective"**
Henry C. Vasconez, MD, Lexington, KY
2:00 PM **"Skeletal Muscle Cardiac Assist"**
Gordin R. Tobin, MD, Louisville, KY
2:30 PM **"The Jejunal Free Flap: External & Internal Coverage"**
Mark E. Chariker, MD, Resident, Louisville, KY
2:45 PM **"Prefabricated Tracheal Reconstruction with Jejunal Flap"**
Kirk A. Churukian, MD, Resident, Louisville, KY
3:00 PM **"Association of Pharyngeal Flaps With Sleep Apnea"**
Tuan Vu, MD, Resident, Lexington, KY
3:15 PM **"Metastatic Basal Cell Carcinoma: A Study of Three Cases"**
Jeannette Martello, MD, Resident, Lexington, KY
3:30 PM **Intermission to visit exhibits**
4:00 PM **"Twenty-five Years Experience in Craniofacial Cleft Surgery"**
Kenneth E. Salyer, MD, Dallas, TX
5:00 PM **"Sternal Infections: An Anatomic Basis"**
Robert D. Acland, MD, Louisville, KY
5:30 PM Adjournment

Ky OB/GYN Society — Ky Section ACOG

Meeting Room 106 — Lower Level — Commonwealth Convention Center
Tuesday, September 20, 1994

12:00 PM **Luncheon in the Hialeah Room, Hyatt**
1:30 PM **"Diagnosis and Management of Polycystic Ovarian Syndrome"**
Arthur F. Haney, MD, Durham, NC
2:10 PM **"Post-Menopausal Bleeding"**
Marvin A. Yussman, MD, Louisville, KY
2:40 PM **"Management of the Perimenopausal Woman"**
Christine L. Cook, MD, Louisville, KY
3:10 PM **Questions and Answers**
3:20 PM **Intermission to visit exhibits**
3:40 PM **"Newer Approaches to Preterm Labor"**
Jonathan Weeks, MD, Louisville, KY
4:10 PM **"Management of the Twin Gestation"**
John A. Read, MD, Lexington, KY
4:40 PM **Questions and Answers**
5:00 PM Adjournment

Ky Orthopaedic Society

Meeting Room 104 — Lower Level — Commonwealth Convention Center
Tuesday, September 20, 1994

1:30 PM **Welcoming Comments**
Patrick J. Serey, MD, Morehead, KY
Jeffrey W. Parr, MD, Lexington, KY
1:35 PM **"Elbow Reconstruction Surgery"**
Bernard F. Morrey, MD, Rochester, MN
2:15 PM **"Results of Two-Year Outcome Study of Total Hip and Knee Replacement"**
Jeffrey W. Parr, MD; Eugene Q. Parr, MD; Lorry Smith, RN, MSN; Peggy H. Parr, PhD, Lexington, KY
2:30 PM **Intermission to visit exhibits**
3:00 PM **"American Academy of Orthopaedic Surgeons and Health Care Reform"**
Bernard F. Morrey, MD, Rochester, MN
3:30 PM **"Osteolysis with a Dual Geometry Acetabular Component in THR"**
Donald L. Pomeroy, MD; Walter E. Badenhausen, MD; Lawrence A. Schaper, MD; Louisville, KY
3:45 PM **"Electron Microscopic Morphologic Investigation of Ultra High Molecular Weight Polyethylene"**
Herbert Kaufer, MD; David Pienkowki, PhD, Lexington, KY
4:00 PM **"Tibiotalocalcaneal Arthrodesis with Medullary Fixation"**
George E. Quill, Jr, MD; Galen A. Weiss, MD; David Seligson, MD, Louisville, KY
4:15 PM **"Recurrent Lumbar Disc Herniation Treated by Repeat Decompression and Fusion"**
John J. Vaughan, MD; H. Brooks Morgan, MD; John Gilbert, MD, Lexington, KY
4:30 PM **"Combined External and Internal Fixation of Unstable Distal Radius Fractures"**
Wagar Aziz, MD; H. Ulson, MD; Thomas W. Wolff, MD; Luis R. Scheker, MD, Louisville, KY
4:45 PM **"MRI Evaluation of Glenoid Labrum in Anterior Shoulder Instability"**
Michael R. Green, Maj, MC; Kevin P. Christensen, MD, Fort Knox, KY
5:00 PM Business Meeting
Patrick J. Serey, MD, Morehead, KY
5:45 PM Adjournment
6:00 PM Reception & Dinner at Vincenzo's "Court Yard"



Ky Chapter
American College of Cardiology

Hialeah Room
Hyatt Regency Hotel
Tuesday, September 20, 1994

5:00 PM Business Meeting and Reception
7:00 PM Adjournment

Ky Chapter, American College of Chest Physicians

Meeting Room 110 — Lower Level —
Commonwealth Convention Center
Tuesday, September 20, 1994

1:30 PM **"A Non-Allergist Looks at Asthma and Allergy"**
Peter S. Kussin, MD, Durham, NC
2:15 PM **"Low Molecular Heparin"**
Jill Ann Ohar, MD, St. Louis, MO
3:00 PM **Intermission to visit exhibits**
3:30 PM **"Update in Treatment of Systemic Fungal Infections"**
Shane E. Vartivarian, MD, Houston, TX
4:15 PM **"Endothelial Factors in Myocardial Ischemia"**
Johnathan Abrams, MD, Albuquerque, NM

Sonia R. Teller, MD, Chair Scientific Program Committee, Presiding

Wednesday, September 21, 1994
Morning General Session
General Sessions Area
Commonwealth Convention Center

8:30 AM Announcements
8:40 AM **"Some Affinities Between Medicine and the Visual Arts"**
M. Therese Southgate, MD, Chicago, IL
9:00 AM **"How the Art of Medicine is Applied in Forensic Pathology"**
Donald E. Henson, MD, Bethesda, MD
9:20 AM **"HIV as a Paradigm for Caring for Chronic Disease: Lessons From Our Patients"**
Andrew T. Pavia, MD, Salt Lake City, UT
9:40 AM **"Myths About Stimulant Treatment"**
Xavier Castellanos, MD, Bethesda, MD
10:00 AM **Intermission to visit exhibits**
10:30 AM **"The Art of Medicine: Mental Illness in Late Life"**
Burton V. Reifler, MD, MPh, Winston-Salem, NC
10:50 AM **"Endoscopic Sinus Surgery: A Better Approach for an Old Problem"**
Kenneth H. Richmond, MD, Louisville, KY
11:10 AM **"Acute and Chronic Pain Management"**
Richard Gregg, MD, Cincinnati, OH
11:30 AM **"Latex Allergy — A Growing Medical Problem"**
Michael S. Blaiss, MD, Memphis, TN
11:50 AM **PRESIDENT'S LUNCHEON**

President's Installation & Awards Luncheon

Wednesday, September 21 — 11:50 AM
Regency Ballroom — Hyatt Regency Hotel

Ardis D. Hoven, MD
KMA President, presiding

Invocation
Recognition

Awards Presentation
Nelson B. Rue, MD, Bowling Green
Chair, KMA Awards Committee

Installation of Robert R. Goodin, MD
KMA President 1994-95

Ky Pediatric Society

Meeting Room 105 — Lower Level —
Commonwealth Convention Center
Wednesday, September 21, 1994

2:15 PM **"Attention Deficit Disorder: An Update for Pediatricians"**
Xavier Castellanos, MD, Bethesda, MD
3:15 PM **Intermission to visit exhibits**
3:45 PM **"Childhood and Adolescent Syncope"**
Francis McCaffrey, MD, Lexington, KY
4:15 PM **TBA**
4:45 PM Adjournment

Ky Psychiatric Association

Meeting Room 110 — Lower Level —
Commonwealth Convention Center
Wednesday, September 21, 1994

2:15 PM **"Alzheimer's Disease: Translating Research Findings into Clinical Practice"**
Burton V. Reifler, MD, MPh, Winston-Salem, NC
3:15 PM **Intermission to visit exhibits**
3:30 PM **"Neuropsychiatric Manifestation of HIV/AIDS"**
Theodore B. Feldmann, MD, Louisville, KY
5:30 PM Adjournment

Ky Chapter, American Academy of Family Physicians

Meeting Room 106 — Lower Level —
Commonwealth Convention Center
Wednesday, September 21, 1994

2:15 PM **"Some Affinities Between Medicine and the Visual Arts"**
M. Therese Southgate, MD, Chicago, IL
3:00 PM **Intermission to visit exhibits**
3:30 PM **"Current Medical Management of Alzheimer's Disease"**
Steven S. Kirzinger, MD, Louisville, KY
4:30 PM Adjournment

Ky Chapter American College of Physicians

General Sessions Area
Commonwealth Convention Center
Wednesday, September 21, 1994

1:45 PM **Registration and Welcome**
Albert B. Hoskins, III, MD, FACP, Louisville, KY
2:00 PM **Associates' Presentation From the University of Louisville and University of Kentucky**
2:45 PM **"HIV — Part I"**
Andrew T. Pavia, MD, Salt Lake City, UT
3:30 PM **Intermission to visit exhibits**
3:45 PM **"HIV — Part II"**
Ardis Dee Hoven, MD, Lexington, KY
4:45 PM **"T.B. in the 90s"**
Julio A. Ramirez, MD, Louisville, KY

Ky Society of Anesthesiologists

Meeting Room 108 — Lower Level —
Commonwealth Convention Center
Wednesday, September 21, 1994

1:30 PM **"Neuralgic Pain Management"**
Richard Gregg, MD, Cincinnati, OH
2:15 PM **"Oral Analgesics in Pain Management"**
Douglas Kennedy, MD
3:00 PM **Intermission to visit exhibits**
3:30 PM **"Cost Effectiveness in the Management of Pain"**
Michael G. Cassaro, MD, Louisville, KY
4:15 PM Fall Business Meeting
5:00 PM Reception

Ky Society of Pathologists

Meeting Room 109 — Lower Level —
Commonwealth Convention Center
Wednesday, September 21, 1994

2:15 PM **"Why Quality Assurance — A Wise Man is Never Surprised"**
Donald E. Henson, MD, Bethesda, MD
2:45 PM **"Practice Protocols — New Cap Initiative"**
Donald E. Henson, MD, Bethesda, MD
3:15 PM **Intermission to visit exhibits**
3:45 PM **"Quo Vadis — Back to the Future"**
Donald E. Henson, MD, Bethesda, MD
4:15 PM Business Meeting
5:15 PM Adjournment



Ky Society of Allergy & Clinical Immunology

Meeting Room 107 — Lower Level — Commonwealth Convention Center
Wednesday, September 21, 1994

1:30 PM **"Outcomes Research in Allergy and Asthma"**
Michael S. Blaiss, MD, Memphis, TN*
2:15 PM **"Allergic Fungal Sinusitis"**
Tim Feger, MD, Augusta, GA
2:40 PM **Intermission to visit exhibits**
3:00 PM **"New Horizons and Controversies in Beta Adrenergic Therapy"**
Stephen J. Pollard, MD, Louisville, KY
3:45 PM **TBA**
4:15 PM **Intermission to visit exhibits**
4:30 PM Business Meeting
5:15 PM Reception in the Gulfstream Room

** An educational grant has been provided by Schering/Key Pharmaceuticals for Dr Michael Blaiss' presentation.*

Ky Society of Otolaryngology Head & Neck Surgery, Inc.

Meeting Room 111 — Lower Level — Commonwealth Convention Center
Wednesday, September 21, 1994

2:15 PM **"Management Reports Every Practice Should Generate and Use"**
Michael J. Buncher, Cincinnati, OH
2:45 PM **"Keeping Your Office Staff Motivated"**
Michael J. Buncher, Cincinnati, OH
3:15 PM **Intermission to visit exhibits**
3:45 PM **"Practice Mergers: Where They Fail"**
Michael J. Buncher, Cincinnati, OH
4:15 PM **"Considering Retiring? Things to Know"**
Roland W. Richmond, MD, Louisville, KY
4:35 PM Business Meeting

Ky Chapter, American College of Emergency Physicians

Meeting Room 107 — Lower Level — Commonwealth Convention Center
Thursday, September 22, 1994

9:00 AM **"Poisoning: Epidemiology, History, and Control"**
Paul M. Wax, MD, Rochester, NY
10:30 AM Adjournment

Ky Occupational Medical Association

Meeting Room 106 — Lower Level — Commonwealth Convention Center
Thursday, September 22, 1994

9:00 AM **"Basics of Wrist Function as Related to Work"**
Bruce Barton, MD, Louisville, KY
9:30 AM **"Syndromes that Mimic Carpal Tunnel Syndromes"**
Michael I. Vender, MD, Arlington Heights, IL
10:00 AM **Intermission to visit exhibits**
10:30 AM **"Maybe the Job is not the Problem"**
Daniel Wolens, MD, Louisville, KY
11:00 AM **"Factitious Injuries"**
Morton L. Kasdan, MD, Louisville, KY
11:30 AM **Panel Discussion: "Back to Work Issues"**
Moderator: Michael I. Vender, MD
Panel Members: Bruce Barton, MD; Daniel Wolens, MD; Morton Kasdan, MD

Ky Association of Public Health Physicians

Meeting Room 104 — Lower Level — Commonwealth Convention Center
Thursday, September 22, 1994

9:00 AM **"Immunization Update"**
Stephen C. Hadler, MD, Atlanta, GA
10:00 AM **Intermission to visit exhibits**
10:30 AM Business Meeting
11:30 AM Adjournment

Ky Academy of Physical Medicine and Rehabilitation

Meeting Room 103 — Lower Level — Commonwealth Convention Center
Thursday, September 22, 1994

9:00 AM **Business Meeting**
9:30 AM **Resident Research Presentations**
University of Kentucky
University of Louisville
10:30 AM **Intermission to visit exhibits**
11:00 AM **"Chronic Pain Syndrome: Evaluation and Treatment"**
Marty Grabois, MD, Houston TX
12:00 PM Adjournment

Ky Society for Gastrointestinal Endoscopy

Meeting Room 105 — Lower Level —
Commonwealth Convention Center
Thursday, September 22, 1994

9:00 AM **"Prospective Randomized Trial of TEN Versus TPN in Acute Pancreatitis"**
Stephen A. McClave, MD, Louisville, KY
9:12 AM **"Mallory Weiss Tear as a Cause of Gastrointestinal Hemorrhage"**
Dona Y. Kortas, MD, Lexington, KY
9:24 AM **"Monitoring of Vital Signs During Conscious Sedation for Endoscopy"**
Antoinette R. Saddler, MD, Lexington, KY
9:36 AM **"Clinical Criteria Required for Use of the Barium Tablet in Diagnosing Structural Lesions of the Esophagus"**
Laszlo Makk, MD, Louisville, KY
9:48 AM **"Management of Esophageal Varices by Band Ligation and Variceal Sclerotherapy"**
Larry Gates, MD, Lexington, KY
10:00 AM **"An Endoscopic Answer to 20 Years of Nausea, Urticaria, and Eosinophilia"**
Ewell G. Scott, MD, Morehead, KY
10:12 AM **Intermission to visit exhibits**
10:30 AM **"Management of Common Bile Duct Stones in the Pericholecystectomy Period"**
Bruce V. MacFadyen, Jr, MD, Houston, TX
11:10 AM **"Retrospective Analysis of the Effect of Contrast Enhanced CT on Acute Pancreatitis"**
Dave McMenamin, MD, Lexington, KY
11:22 AM **"Endoscopic Palliation of Malignant Esophageal Obstruction"**
Whitney Jones, MD, Louisville, KY
11:37 AM **"Endoscopic Treatment of Biliary Strictures"**
Gary Vitale, MD, Louisville, KY
11:55 AM Board Meeting
12:20 PM Luncheon

Ky Dermatological Society

310 E Broadway
Louisville, KY
Thursday, September 22, 1994

1-2 PM **Patient Viewing at 310 E Broadway**
2:30 PM **"Purpura Morphology: When Vasculitis Isn't an 'itis'"**
Warren W. Piette, MD, Iowa City, IA
3:30 PM Patient Discussion
4:30 PM Business Meeting

Ky Geriatrics Society

Meeting Room 108 — Lower Level —
Commonwealth Convention Center
Thursday, September 22, 1994

9:00 AM **"The Art of Pressure Sore Care"**
Richard Alman, MD, Birmingham, AL
10:00 AM **"Nutritional Assessment of the Elderly"**
Nancy Stiles, MD, Lexington, KY
10:45 AM **Intermission to visit exhibits**
11:15 AM **"Management of Difficult Behaviors in Elderly Patients"**
Christine L. Tully, MD, Lexington, KY
12:00 PM Adjournment

CONTINUING MEDICAL EDUCATION

The Kentucky Medical Association designates this continuing medical education activity for 15.0 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. One credit hour may be claimed for each hour of participation by the individual physician.

The Kentucky Medical Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

THE ART OF MEDICINE

General Sessions Learning Objectives

HIV as a Paradigm for Caring for Chronic Disease: Lessons From Our Patients

Andrew T. Pavia, MD

Participants will evaluate the duration of HIV disease and the impact of interventions; explore the benefits of preventive care and comfort prolonging care; and will review the role of the physician in illnesses which cannot be cured by surgery or medicine.

Advances in the Art of Ophthalmology

Ronald E. Smith, MD

Participants will assess current treatments in diabetes and new initiatives from the American Academy of Ophthalmology in the Diabetes 2000 program, and will evaluate the newest techniques in cataract surgery (advantages and disadvantages).

New Concepts in Total Hip Arthroplasty

Bernard F. Morrey, MD

Participants will be exposed to the uncemented implant with favorable long-term compatibility characteristics.

The Art of Medicine: Mental Illness in Late Life

Burton V. Reifler, MD

Participants will identify the major mental illnesses affecting individuals in late life and will review community resources for psychiatrically impaired elderly.

What To Do With the Recurrent Stone Former

Joseph W. Segura, MD

Participants will review the evaluation, management, and treatment of patients who develop recurrent kidney stones.

Latex Allergy — A Growing Medical Problem

Michael S. Blaiss, MD

Participants will differentiate the types of reactions to latex in man; will review what groups are at increased risk for developing latex allergy; and will examine the principles or workup and management of patients with possible latex allergy.

New Technology in Neurosurgery

George T. Tindall, MD

Participants will relate the status of the neuroendocrinology, investigation, and surgical treatment of pituitary tumors. The cooperative integrated role of the endocrinologist, radiologist, and neurosurgeon is highlighted in this presentation.

Some Affinities Between Medicine and the Visual Arts

M. Therese Southgate, MD

Participants will review many of the masterpieces of art that have been featured on *JAMA* covers over the past 30 years; will explore some similarities that exist between art and medicine; will identify some of the qualities that are common to great artists and great physicians; will recall the appropriate relationship of science and technology to both the visual arts and to medicine; and will establish the reciprocal identities of medicine and art: the physician as artist, art as medicine.

Women in the Perimenopausal Transition

Arthur F. Haney, MD

Participants will be able to identify the perimenopausal transition as a distinct interval of transition from the years of normal reproductive menstrual cycles to failure of ovarian function after menopause; will characterize the hormonal profile of the perimenopausal transition; will understand the common clinical problems encountered in this interval; and will appreciate the therapeutic options available and counsel patients as to their relative risks and benefits.

Myths about Stimulant Treatment

Xavier Castellanos, MD

Participants will review the issues regarding treatment of children and adolescents with Ritalin, amphetamines, etc; will learn proper dosage of stimulants in children and adolescents; and will become acquainted with abusable versus nonabusable uses of stimulants.

The Art and Science of Craniofacial Surgery

Kenneth E. Salyer, MD

Participants will review various aspects of the art inherent in plastic surgery and will discuss relevant points and ideas among plastic surgeons.

Asthma: State of the Art

Peter S. Kussin, MD

Participants will assess the importance of compliance in management of asthma; will examine the rationale for self-management in asthma; will analyze techniques for improving and monitoring compliance; and will be able to design an appropriate fitness and exercise regimen for the patient with asthma.

Everything You Wanted to Know About Graves' Disease

David V. Feliciano, MD

Participants will review the history of Graves' Disease; will access acceptable forms of therapy; and will analyze current surgical approaches and the results of surgical approaches in Graves' Disease.

How the Art of Medicine is Applied in Pathology

Donald E. Henson, MD

Participants will develop a better understanding of the art of medicine and its far reaching applications, with specifics regarding pathology and forensic pathology.

Acute and Chronic Pain Management

Richard V. Gregg, MD

Participants will develop a better understanding of acute, chronic benign, and ma-

lignant pain, and will examine a reasonable approach for each of these pain problems. Participants will also examine the "tissue source" viewpoint for pain, develop assessment criteria of pain specialists' abilities and focus, and establish some reasonable criteria for referral to pain management specialists.

Endoscopic Sinus Surgery: A Better Approach for an Old Problem
Kenneth H. Richmond, MD
Participants will be able to describe the role of the osteo-meatal complex in sinus disease and how both endoscopic examination and CT scanning of the paranasal sinuses improves diagnostic accuracy. Participants will analyze endoscopic techniques in the surgical treatment of sinus disease which can completely eradicate chronic sinus disease and resolve symptoms with minimal surgical intervention.

AN INVITATION TO ALL SENIOR AND/OR RETIRED MEMBERS OF KMA TO THE STATEWIDE CATO SOCIETY MEETING OF THE SENIOR PHYSICIANS OF JEFFERSON COUNTY 9:30 AM WEDNESDAY, SEPTEMBER 21, 1994 THE HYATT REGENCY HOTEL, LOUISVILLE, KY

Here is an opportunity for senior and/or retired members of KMA to meet old colleagues and make new friends at the 5th Annual Statewide CATO Society Meeting, held during the KMA Annual Meeting.

The CATO Society is an integral part of the Jefferson County Medical Society and its Senior Physicians Committee. We have meetings in the Spring and Fall that are primarily for fellowship. We gather for a light meal followed by an enlightening but brief address on some informative or entertaining topic.

Last year's meeting was an immense success with a large crowd of senior physicians from the Kentuckiana area.

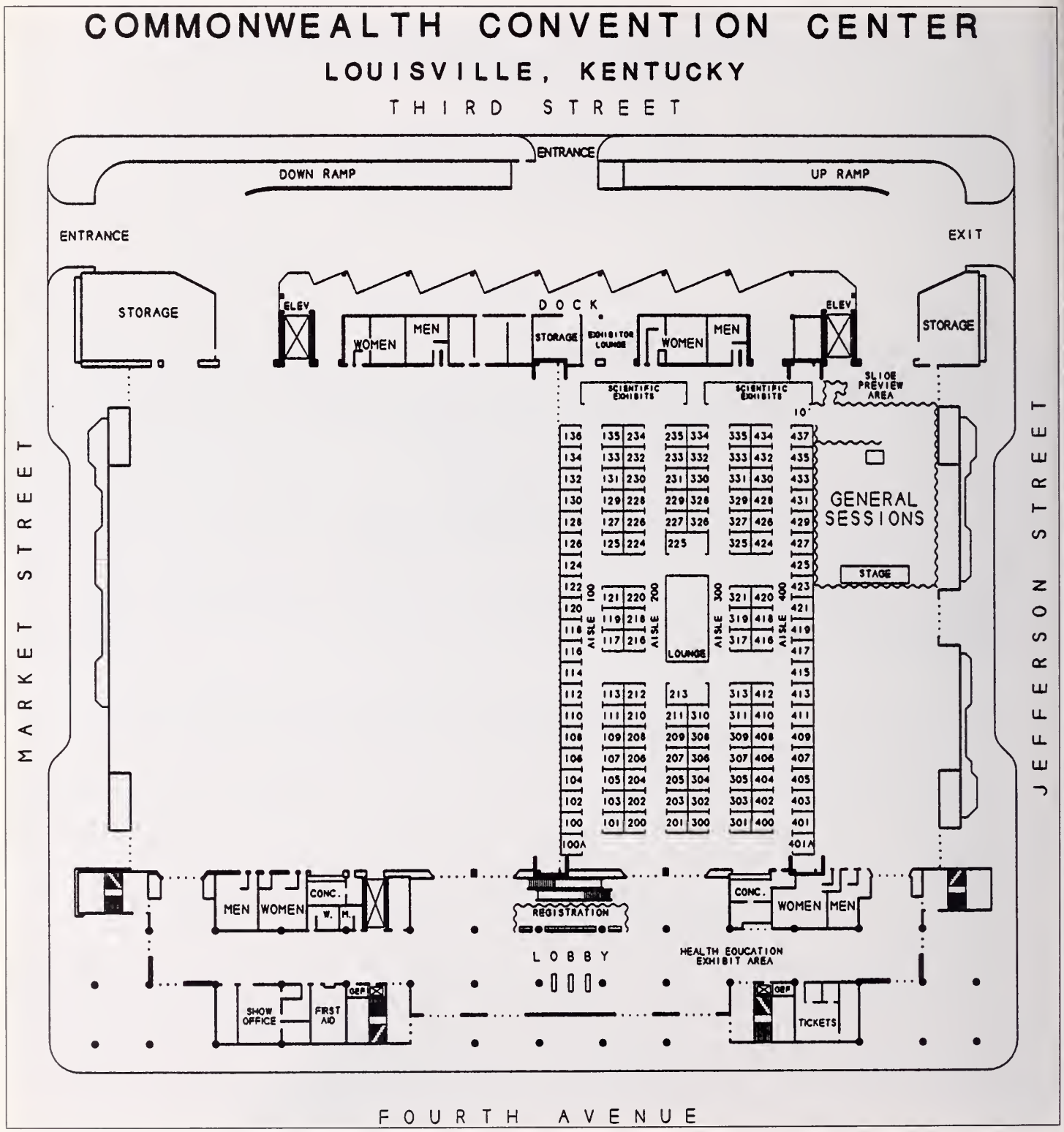
This year we cordially invite spouses and widows to attend.

Watch the mail for your invitation, complete the form, and share a time during brunch with your colleagues. We look forward to visiting with you.

Harold G. Eskind, MD
Chairman, Statewide CATO Society

Eugene H. Conner, MD
President, Jefferson County CATO Society

EXHIBIT HALL FLOOR PLAN



All exhibitors with corresponding booth space(s) are listed on this map of the Exhibit Hall. We regret that due to printing and publication deadlines, not all exhibitors are represented in this Exhibit Guide. For more detailed information on the exhibitors, refer to the Technical Exhibits listing beginning on page 340, and please visit them in the Exhibit Hall.

TECHNICAL EXHIBITOR DIRECTORY

Exhibitor	Booth
Abbott Laboratories	213
ACOM Corporation	331
AdminaStar of Kentucky	220
Alliant Health System	311
AllMed Financial Corp	102
American Physicians Life	407
Applachian Regional Healthcare	334
Astra/Merck	211
Attention Control Training	419
Berlex Laboratories	319
Bristol-Myers Squibb	227
Canon USA, Inc	403
Cardinal Hill Rehabilitation Hospital	432
CAREFLIGHT Air Medical Service	300
Caretenders Healthcorp	203
Carlin Institute of Wellness	329
Carnrick Labs, Inc	204
Charter Ridge Hospital	207
Clayton L. Scroggins Associates, Inc	425
Coastal Emergency Services	401
Columbia/HCA Louisville Hospitals	406
Division of Disability Determinations	428
Eli Lilly & Company	317
Encore, Inc	326
First Step Pregnancy Counseling and Adoption Services	304
Fisons Pharmaceuticals	302
Floyd Memorial Hospital	411
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Glaxo, Inc	405
Good Samaritan Hospital	234
Grogan's Inc	325
Health Financial, Inc	307
HealthStar, Inc	117
Healthware, Inc	413
Hoechst-Roussel Pharmaceuticals, Inc	309
Jewish Hospital HealthCare Services	100A
Kentucky Air National Guard	424
Kentucky Army National Guard	212
Kentucky Hospital Insurance Agency	409
Kentucky Medical Insurance Company/ KMA Insurance Agency, Inc/ United Leasing, Inc	321 & 420
Kentucky Medical Review Organization	134
Kentucky Organ Donor Affiliates	106
Kentucky Telco Federal Credit Union	423
Key Pharmaceuticals	434
Knoll Pharmaceutical Company	401A
Lederle Laboratories	301
Lincoln Trail Hospital	124
Marion Merrell Dow, Inc	327
MD Systems	335
Mead Johnson Nutritionals	235
Medfax Corp.	121

Exhibitor	Booth
Medic Computer Systems, Inc	114
Med Monitoring Systems, Inc	113
Med-Systems Management, Inc.	404
Mediation First	112
The Medical Protective Company	225
Mediplex Rehab	410
Merck Vaccine Division & Merck Human Health Division	306
Miles, Inc	104
Milex Products, Inc	333
Mosby/Churchill/Waverly, Inc	202
Muro Pharmaceutical, Inc	205
National Health Laboratories	427
Northwestern Mutual Life	303
Norton Psychiatric Clinic	330
Olsten Kimberly QualityCare	430
Olympus America, Inc	216
Ortho Pharmaceuticals	200
Our Lady of Peace Hospital	226
Pfizer Labs	224
Physio-Control Corporation LIFEPAK®	328
The PIE Mutual Insurance Company	416
Pikeville Methodist Hospital	233
Pratt/Pfizer	125
Ransdell Surgical, Inc	210
Republic Bank & Trust Company	415
Rhone-Poulenc Rorer Pharmaceuticals, Inc	310
Roche Biomedical Laboratories	435
Roche Laboratories	116
Roerig/Pfizer	228
Ross Products Division of Abbott Laboratories	418
Saint Joseph Hospital	402
Saints Mary & Elizabeth Hospital	308
Salcris Systems	136
Schering Laboratories	305
Searle	429
SKYCARE	100
Smith Barney	412
SmithKline Beecham	101
SmithKline Beecham Clinical Laboratories	313
Southeastern Group, Inc	218
Southern Medical Association	109
3M Pharmaceuticals	431
Ten Broeck Hospital	426
UAD Laboratories	417
Unico, Inc	122
United States Air Force	437
University of Kentucky Hospital Chandler Medical Center	421
The Upjohn Co	408
Wyeth-Ayerst Laboratories	201
Zeneca Pharmaceuticals	433

TECHNICAL EXHIBITS

Plan to visit the Exhibit Hall during the KMA Annual Meeting. Trained professional representatives of more than 100 firms will be on hand to discuss with you the details of their products and services in a relaxed atmosphere — with no patients waiting in your outer office and with no telephones ringing.

Located in the Commonwealth Convention Center, the exhibits will condense a volume of information and ideas in such a manner that a vast amount of knowledge can be secured in a short period of time.

The Exhibit Hall is an important part of the Annual Meeting and is the site of registration for all CME courses.

Thirty-minute intermissions have been planned during each general and specialty group session so that every physician may take advantage of this opportunity to benefit their practice and their patients.

Abbott Laboratories **#213**
One Abbott Park Road
Abbott Park, IL 60064-3500
(708) 937-7141

ACOM Corporation **#331**
400 Embassy Square Blvd, Suite 401
Louisville, KY 40299
(502) 491-7451

AdminaStar of Kentucky **#220**
9901 Linn Station Rd
Louisville, KY 40223
(606) 233-1436
Medicare Fiscal Intermediary and Carrier for the Commonwealth of Kentucky. "Stop by our Exhibit and talk to one of our representatives and see a demonstration of our free software for Medicare claims submission."

Alliant Health Systems **#311**
PO Box 35070
Louisville, KY 40232-5070
(502) 629-8652
— Lighted Company Name Display with photographs of hospital services
— Printed Brochures and pamphlets of services and physician information
— Alliant Logo and promotional items will be displayed on a table for distribution
— Registered Nurses from the Physician Services Department will be in attendance.

AllMed Financial Corp **#102**
8910 Purdue Road, Suite 300
Indianapolis, IN 46268
(317) 228-5100
AllMed Financial Corp, a subsidiary of The Associated Group, offers three primary solutions to problems facing today's providers:
1) Funding and finance programs for physicians and patients.
2) Processing services for billing and insurance claims.
2) Practice management systems for total office automation.

American Physicians Life **#407**
PO Box 16182
Pickerington, OH 43147
(614) 864-3900
Regional life insurance company providing specialized insurance and financial service programs to physicians, their family and office staff.

Appalachian Regional Healthcare **#334**
1220 Harrodsburg Road
Lexington, KY 40504
1-800-888-7045
ARH is recruiting physicians of all specialties to its rural hospital and clinic locations in eastern Kentucky, West Virginia, and southwest Virginia. We offer solo, group, and hospital-employed practices with excellent salaries, benefits, and incentives. Representatives can provide you with literature.

Astra/Merck Group of Merck & Co, Inc **#211**
5110 Maryland Way, Suite 190
Brentwood, TN 37027
(615) 371-5288
Astra/Merck Group of Merck & Co, Inc is dedicated to revolutionizing the pharmaceutical industry by being the best at linking patients and products through unique, responsive, customer-shaped pharmaceutical solutions. Our commitment is to provide customized services and new programs designed to meet local and national issues along with quality products.

Attention Control Training, Inc **#419**
4010 Dupont Circle, Suite 517
Louisville, KY 40207
(502) 899-9550
Attention Control Training provides a non-pharmacological approach to treating attention deficit disorder — with or without hyperactivity — and other problems. Published research and clinical experience indicates that EEG biofeedback, or neurotherapy, produces substantial improvement of ADD, ADHD, epilepsy, stroke and head injury, learning disorders, anxiety, depression, substance abuse, and chronic pain. Services provided include EEG (brainwave) biofeedback therapy, evaluations using Quantitative EEG paired with cognitive challenges, and the Test of Variables of Attention. Neurotherapy teaches patients to concentrate and relax when each is appropriate.

Berlex Laboratories **#319**
300 Fairfield Road
Wayne, NJ 07470
(201) 305-5082

Bristol-Myers Squibb **#227**
P.O. Box 4500
Princeton, NJ 08543-4500
(609) 897-2000
We cordially invite you to visit our exhibit to meet our representatives who welcome the opportunity to discuss products and services of interest to you.

Canon USA, Inc **#403**
100 Park Boulevard
Itasca, IL 60143
(708) 250-6435

Cardinal Hill Rehabilitation Hospital **#432**
2050 Versailles Road
Lexington, KY 40504
(606) 254-5701
Cardinal Hill Rehabilitation Hospital is a non-profit physical rehabilitation center in Lexington, Kentucky. With a license for 100 inpatient beds and modern facilities and equipment for outpatient programs, Cardinal Hill provides a wide range of therapy and services to meet the needs of adults and children with all types of disabling conditions. A team of physical rehabilitation specialists work together to meet the needs of each patient.

Careflight Air Medical Service Saint Joseph Hospital **#300**
One Saint Joseph Drive
Lexington, KY 40504
(606) 278-9811
Careflight Air Medical Service, based at Saint Joseph Hospital in Lexington, Kentucky, is available 24 hours a day for emergency transport of critically ill and injured patients. Our helicopter is a twin engine MBB BK 117 staffed by a pilot and specially trained RNs and paramedics skilled in the management of life threatening situations. We carry a full complement of emergency equipment and medications to deliver advanced life support. Our communication

specialists are always available to coordinate patient flights and referrals at 1-800-678-9811. Please stop by booth 300 to discuss the capabilities of our flight team.

Caretenders **#203**
9200 Shelbyville Road, 810
Louisville, KY 40222
(502) 425-4701
Comprehensive home health services throughout much of Kentucky, with offices in Louisville, Lexington, Elizabethtown, Owensboro, and Danville.

Carlin Institute of Wellness, Inc **#329**
2607 Preston Highway
Louisville, KY 40217
(502) 636-3648
Focusing on lifestyle changes. We use hypnotherapy, wellness, massage therapy, behavior modification, coaching, teaching and counseling to help our clients change eating habits, develop strong exercise/activity patterns, quit smoking and manage stress. We will offer free shoulder massages by our licensed massage therapist and videos or one-on-one discussions of how to use the power of suggestion with patients to help them make lifestyle changes for wellness. Diane Carlin, RN, MSN, is a certified and registered hypnotherapist and has been in business since 1980.

Carnrick Labs, Inc **#204**
65 Horse Hill Road
Cedar Knolls, NJ 07927
(201) 267-2670

Charter Ridge Hospital **#207**
3050 Rio Dosa Drive
Lexington, KY 40509
(606) 268-6448
Located in the Bluegrass Region of Central Kentucky, Charter Ridge is a 110 bed psychiatric and addictive disease hospital. We offer inpatient programs for children, adolescents and adults. "WINGS," a Christian Therapy track is available for those wishing to receive Christian based treatment. Chemical dependency treatment for police officers and public safety professionals is available on a specialized treatment track. We offer partial programs for adult and adolescent psychiatric patients and adult addictive disease patients. Free confidential screenings or referrals are available.

Clayton L. Scroggins Associates, Inc **#425**
200 Northland Blvd
Cincinnati, OH 45246
(513) 771-7070
Scroggins Associates brings to your practice Management Consulting expertise gained not only from doing in-depth consultations for hundreds of doctors each year, but also from working with our continuing client base. Let us help you stay competitive in today's changing environment.

Coastal Emergency Services of Memphis, Inc **#401**
965 Ridgelake Blvd, Suite 305
Memphis, TN 38120
(901) 767-1301
Coastal Emergency Services is a practice management service for Emergency Departments. Physicians contract with our company to practice and provide coverage in the Emergency Departments.

Columbia/HCA Healthcare Corporation **#406**
c/o Suburban Medical Center
4001 Dutchmans Lane
Louisville, KY 40207
(502) 893-1218
The Columbia/HCA Healthcare Network of Louisville includes Audubon Regional Medical Center, Southwest Hospital, Suburban Medical Center, University of Louisville Hospital, and James Graham Brown Cancer Center. Columbia/HCA is the largest healthcare provider in the nation, employing more than 130,000 people in more than 190 hospitals and other healthcare facilities in 26 states, England, and Switzerland. The Columbia/HCA hospitals of Louisville offer convenient access to advanced technology, comprehensive services and cost-effective, high quality healthcare.

Division of Disability Determinations **#428**
PO Box 1000
Frankfort, KY 40601
1-800-928-8050 ext 4024
Obtaining good medical evidence and maintaining an adequate panel of consulting physicians is vital to the functioning of the Social Security Disability program. Representatives of the Kentucky Division of Disability Determinations Services (DDS) exhibit at professional medical conventions at local and state levels to promote understanding of the medical needs of the disability program. Through understanding, the medical community and DDS can work together to serve the needs of Kentucky's disabled.

Eli Lilly and Company **#317**
Lilly Corporate Center, DC 1845
Indianapolis, IN 46285
(317) 276-2554
Eli Lilly and Company welcomes the opportunity to support your organization through participation in your exhibit program. We cordially invite you to visit our display and discuss any inquiries you may have concerning Prozac® (fluoxetine hydrochloride, Dista), Humulin® (human insulin of recombinant DNA origin, Lilly), Axid™ (nizatidine, Lilly), Lorabid™ (loracarbef, Lilly), and Ceclor® (cefaclor, Lilly).

Encore, Inc **#326**
2300 Plantside Drive
Louisville, KY 40299
(502) 499-1556
Vacuum Therapy for the Treatment of IMPOTENCE.

First Step Pregnancy Counseling & Adoption Services **#304**
10801 Shelbyville Road
Middletown, KY 40243
(502) 244-9319
First Step provides a wide range of pregnancy counseling services regardless of whether the birth mother chooses to parent the child or place the child for adoption. Masters level counselors provide professional and confidential adoption services, assisting birth mothers and adoptive parents in developing an adoption plan that is best for them.

Fisons Pharmaceuticals **#302**
9013 Bingham Drive
Louisville, KY 40242
(502) 425-6362
Fisons is a world leader in allergy and asthma research. Stop by our booth for the latest technical information on this rapidly changing field.

Floyd Memorial Hospital **#411**
1850 State Street
New Albany, IN 47150
(812) 949-5572
As the largest acute care facility in southern Indiana, Floyd Memorial Hospital (FMH) was named one of the top 100 facilities across the nation in a study by HCIA (a com-

prehensive health care information source) and Mercer (a leading international consulting firm). With a service area of 250,000, FMH provides the most advanced technology available today along with immediate expert consultations in more than 29 specialties. Our level II Trauma Center is staffed by BC emergency physicians with 24-hour coverage. Floyd County is a diverse community offering charm and security for its 65,000 citizens while bordering the major metropolitan area surrounding Louisville. Stop by our booth to discuss practice opportunities in Floyd County, Indiana.

Fujisawa USA, Inc **#400**
Three Parkway North
Deerfield, IL 60015-2548
(708) 317-8841
Fujisawa USA, Inc offers the latest in drug delivery systems, cardiovasculars, micronutrients: HIV-related medications, and anti-infectives, all designed to meet your changing needs.

Glaxo, Inc **#405**
5 Moore Drive
Research Triangle Park, NC 27709
1-800-545-2965
Glaxo, Inc, headquartered in Research Triangle Park, NC, is the US subsidiary of London-based Glaxo Holdings, PLC, the second largest pharmaceutical company in the world, Glaxo Holdings has more than 48,500 employees in some 70 countries. Glaxo medicines are sold in about 150 countries.

Glaxo is an integrated research-based group of companies whose corporate purpose is to create, discover, develop, manufacture and market throughout the world safe, effective medicines of the highest quality, which will bring benefit to patients through improved longevity and quality of life, and to society in general through economic value.

Good Samaritan Hospital **#234**
310 South Limestone Street
Lexington, KY 40508
(606) 252-6612
The Good Samaritan Hospital exhibit will focus on leading services — including obstetrics, orthopedics and minimally invasive procedures — through both strong art elements and printed materials. Clinical and physician education personnel will be available to talk with booth visitors, and to answer questions about Good Samaritan's leadership role in developing a new type of management/operational structure to meet the challenges of a health care reform environment.

Grogan's Healthcare Supply, Inc **#325**
1016 S Broadway
Lexington, KY 40504
(606) 254-6661
Join us in Grogan's booth for a look at in-office lab equipment and surgical instruments.

Health Financial, Inc. **#307**
3320 Tates Creek Road, Suite 101
Lexington, KY 40502
(606) 266-5211
Health Financial provides money management and pension plan management to physicians and dentists. Services include day to day asset management, trust services, pension plan documents and complete annual administration for all types of qualified retirement plans. Assets are managed without commissions and in a very cost efficient environment. Health Financial was organized by Dr Gregory W. Kasten and currently manages in excess of $150 Million in assets.

HealthStar, Inc. — Kentucky Division **#117**
9300 Shelbyville Road, Suite 215
Louisville, KY 40222
(502) 425-9447
HealthStar, Inc's Managed Care Division is a privately owned national preferred provider organization (PPO) established in 1984 as an Illinois corporation. HealthStar is committed to managed care as a viable means of providing cost-effective, quality health care and is continually adapting to meet the needs of a changing marketplace. HealthStar is headquartered in Lincolnwood, Illinois with networks established in Alabama, Georgia, Illinois, Iowa, Kentucky, Nebraska, and Ohio totaling more than 400 hospitals and over 18,500 physicians.

Healthware, Inc **#413**
340 North Dixie Boulevard
Radcliff, KY 40160-1305
1-800-942-2552
Healthware, Inc specializes in automating physicians offices and is Kentucky's largest Medical Manager Dealer with over 110 installations. The Medical Manager can assist an office with electronic claims, electronic remittance, appointment scheduling, SOAP notes, patient billing, and all other areas of office management. Combined with Healthware's cash flow guarantee, unlimited software support, and unlimited on-site training, we offer physician's offices an unsurpassed value.

Hoechst-Roussel Pharmaceuticals, Inc. **#309**
Route 202-206, P.O. Box 2500
Somerville, NJ 08876
(908) 719-5825
We cordially invite you to visit our exhibit where our top sales representatives will welcome the opportunity to share information with you on our product line. Featured will be Trental® (pentoxifylline), Diabeta® (glyburide), Claforan® (cefotaxime sodium), and Altrace™ (ramipril). Altace™ is jointly marketed by Hoechst-Roussel Pharmaceuticals Incorporated and The Upjohn Company.

Jewish Hospital HealthCare Services **#100A**
217 E Chestnut Street
Louisville, KY 40202
(502) 581-0907
In support of Jewish Hospital HealthCare Services' network physicians, the Physician/Hospital Development Department offers a comprehensive program to assist the private practice physician in building a practice and managing it effectively. Strategic planning resources are available to enhance the physician's service to the community.

Kentucky Air National Guard **#424**
1019 Old Grade Lane
Louisville, KY 40213-2623
(502) 364-9424
The Kentucky Air National Guard is a Reserve Component of the Air Force. It offers physicians and other medical professionals the opportunity to serve their state and nation in a unique way. Many doctors train to be Flight Surgeons which gives you the chance to fly, something no other part time career can offer. You also receive good pay, benefits, retirement, and other valuable training that will enhance your career now and in the future.

Kentucky Army National Guard Medical Recruiting **#212**
Boone National Guard Center
Frankfort, KY 40601-6168
(502) 564-8575
Today, the mission of the Army National Guard is a dual one, state and federal. It

offers physicians and other medical professionals the opportunity to serve their state and nation in a unique way. Many doctors train to be flight surgeons, battalion surgeons, general medical officers and other specialties, which gives the opportunities that no other part-time career can. You also receive good pay, benefits, retirement, and other valuable training that will enhance your career. The Kentucky Army National Guard Recruiting Team will be available to answer any questions and give out literature. Stop in and see us or give us a call at 1-800-372-7601 ext 575.

Kentucky Hospital Insurance Agency **#409**
1302 Clear Spring Trace
Louisville, KY 40224
(502) 426-6220
Kentucky Hospital Insurance Agency provides a full range of property & casualty and life & health insurance products and services to health care providers, including KHSC's three trusts: Kentucky Hospital Association Trust (KHAT) for hospital professional liability, Compensation Hospital Association Trust (CHAT) for workers' compensation, and Kentucky Hospital Employee Health Benefit Trust (KHEHBT) for health benefits.

Kentucky Medical Insurance Company/ KMA Insurance Agency, Inc/ United Leasing, Inc **#321 & 420**
303 North Hurstbourne Parkway
Louisville, KY 40222-5143
(502) 339-5700
Established by the Kentucky Medical Association (KMA) during the insurance crisis of the mid-70's to give physicians more control over their own destiny. Our directive from the KMA was simple: provide adequate prices, maintain financial strength, and don't bail out when times are tough. United Leasing can provide medical equipment, office equipment and vehicles at affordable rates. Services Available: Professional Liability, Leasing, KMIC Retirement Trust, KMA Insurance Agency, Hospital Division. Service Area: All of Kentucky.

Kentucky Medical Review Organization **#134**
PO Box 23540
10503 Timberwood Circle
Louisville, KY 40223
(502) 339-7442
Kentucky Medical Review Organization is the Kentucky physician-directed medical Peer Review Organization (PRO) that contracts with the Federal Government to oversee the medical care provided to Medicare beneficiaries.

Kentucky Organ Donor Affiliates (KODA) **#106**
305 W Broadway, Suite 316
Louisville, KY 40202
(502) 581-9511
KODA is an independent, non-profit, federally certified organ and tissue procurement agency. KODA's goal is to ensure that Kentuckians are aware of the options of organ and tissue donation, and that they have the information necessary to make individual, informed choices regarding donation. KODA works closely with the hospitals in its service area, offering assistance to healthcare professionals with regard to organ and tissue donation, procurement and transplantation.

Kentucky Telco Federal Credit Union **#423**
3740 Bardstown Road
Louisville, KY 40218
(502) 459-3000
The KMA Credit Union. Offer your staff a fringe benefit that won't cost you a cent! Kentucky Telco is a federal credit union with service centers located in Louisville, Lexington, Owensboro and Frankfort, all delivering full financial services, with federally insured savings, low cost loans, credit cards with no annual fee, Quest ATM services, 24 hour telephone response system, and much more. Kentucky Telco is proud to be the only financial institution endorsed by the Kentucky Medical Association.

Key Pharmaceuticals **#434**
2000 Galloping Hill Road
Kenilworth, NJ 07033
(908) 298-4000
Exhibiting Key Pharmaceuticals line of cardiovascular and respiratory medications. The two newest additions include IMDUR, a once a day oral extended release formulation of isosorbide mononitrate for the prevention of angina pectoris due to coronary artery disease and Claritin, a long acting once a day antihistamine indicated for the relief of nasal and non-nasal symptoms of seasonal allergic rhinitis.

Knoll Pharmaceutical Company **#401A**
30 North Jefferson Road
Whippany, NJ 07981
(201) 887-8300

Lederle Laboratories **#301**
One Cyanamid Plaza
Wayne, NJ 07470
(201) 831-4422

Lincoln Trail Hospital **#124**
3909 South Wilson Road
Radcliff, KY 40160
(502) 351-9444
Lincoln Trail Hospital offers adult and adolescent psychiatric and chemical dependency treatment on an inpatient and outpatient basis. Our team of professionals, including psychiatrists, psychologists, counselors, social workers, nurses, activity therapists and dieticians are dedicated to assuring the very best patient care available. Through individualized and group therapy, education and treatment planning, individuals are provided the tools to achieve successful recovery from mental illness and chemical dependency.

Marion Merrell Dow Inc **#327**
9300 Ward Parkway
Kansas City, MO 64114
(816) 966-4928
Marion Merrell Dow Inc invites you to visit our booth, where our representatives will be happy to discuss, Cardizem® Injectable (diltiazem hydrochloride), Cardizem® CD (diltiazem hydrochloride), Nicoderm® (nicotine transdermal system) and Carafate® (sucralfate).

Mead Johnson Nutritionals **#235**
2400 West Lloyd Expressway
Evansville, IN 47721-0001
(812) 429 5000
We cordially invite you to visit our exhibit to meet our representatives who welcome the opportunity to discuss products and services of interest to you. Featured will be: Enfamil; Lactofree; Next Step; Nutramigen; ProSobee; Sustacal; and Tempra.

MD Systems **#335**
1170 E Broadway
Louisville, KY 40204
(502) 589-3207

Mediation First **#112**
101 Crescent Avenue
Louisville, KY 40206
(502) 897-3020
Mediation First is a full service regional mediation firm with offices in Louisville and Atlanta that has created a system of past due account recovery employing the principles of mediation. We have been successful in recovering more than 70% of all past-due accounts referred at a rate far lower than traditional collection methods.
In an uncertain and changing health care climate, we are helping the medical community focus on a difficult, continuing problem without alienating patients.

MEDIC Computer Systems, Inc **#114**
11260 Chester Road, Suite 160
Cincinnati, OH 45246
(513) 771-5790
Medic is a complete office management system consisting of hardware, software, support & maintenance.

Med Monitoring Systems, Inc. **#113**
689 Rivercrest Lane
Longwood, FL 32779
1-800-749-6333
Med Monitoring Systems, Inc sell Holter Monitoring, EKG, and Pulmonary Function Equipment. We represent the Southeast, selling to physicians, hospitals, and clinics.

The Medical Protective Company **#225**
5814 Reed Road
Fort Wayne, IN 46835
(219) 485-9622
The Medical Protective Company has been defending doctors against allegations of malpractice since 1899. The largest insurer of doctors in the country, The Medical Protective Company offers both occurrence and claims-made coverage, and specializes in professional liability insurance for the health care community. Premium discounts are available for completing approved risk management programs, as well as significant loss-free discounts for doctors who are claim-free.

Mediplex Rehab **#410**
1300 Campbell Lane
Bowling Green, KY 42104
(502) 782-6900

Merck Vaccine Division and Merck US Human Health **#306**
Division of Merck & Co, Inc
Sumneytown Pike
West Point, PA 19486
(215) 652-8790
The Merck Vaccine Division and Merck US Human Health Division of Merck & Co, Inc invite you to visit our exhibit. Our representatives will be happy to answer your questions about our services, and our lines of vaccines and pharmaceuticals.

Miles, Inc **#104**
7700 Bonhomme Ave, Suite 325
St Louis, MO 63105
1-800-998-1838

Milex Products **#333**
5915 Northwest Highway
Chicago, IL 60631
1-800-621-1278
Milex Products has three major product categories:
1) Medications — Preparations used in treating female problems.
2) Disposables — Items used in gynecological diagnosis and treatment. (Variety of cancer screening products, vaginal supportive pessaries, diaphrams, dilators, word catheters, and infertility products.)
3) Educational materials — Books and teaching aids that assist in opening the lines of communication between patient and medical staff and convey additional information to the patient and patient's family.

Mosby/Churchill/Waverly, Inc **#202**
17212 Little Eagle Creek Ave
Westfield, IN 46074-9646
1-800-383-9166
Mosby/Churchill/Waverly, Inc is a joint venture of the leading companies in Medical publishing. Hot new books include new editions of Auerbach, *Management of Wilderness and Environmental Emergencies, 3e*, Miller, *Anesthesia 4e*, and Kahn, *Joslin's Diabetes Mellitus 13e*. Other best sellers include the new *Harrison's Principles of Internal Medicine, 13e* and a fantastic new book by Griffith, *The 5 Minute Clinical Consultant 1994*. Along with our many new texts, we also have beautiful new color atlases, slide atlases, productivity enhancing software, CME certified laserdiscs, instructional videotapes, CD-ROM, and several new journals.

MURO Pharmaceutical, Inc **#205**
890 East Street
Tewksbury, MA 01876-1496
(508) 851-5981
You are cordially invited to visit the booth of Muro Pharmaceutical, Inc to discuss Muro's fine product line. We are exhibiting Volmax® (albuterol sulfate) Extended-Release Tablets; Bromfed® Capsules, Bromfed-PD® Capsules, Bromfed-DM® Syrup, and Bromfed® Syrup, our antihistamine-nasal decongestant family; Guaifed® Capsules, Guaifed-PD® Capsules, Guaifed® Syrup, and Guaitab® Tablets, our nasal decongestant-expectorant family; and Prelone® syrup, our concentrated liquid steroid. Please stop by Muro's booth to learn more about these products.

National Health Laboratories, Inc **#427**
4500 Conaem Drive
Louisville, KY 40213
(502) 456-4700
Full service reference laboratory providing high quality testing and a comprehensive service program. Customized services tailored to fit your individual needs. Quality is top priority!

Northwestern Mutual Life **#303**
462 South Fourth Avenue, Suite 1900
Louisville, KY 40202
(502) 562-2429
Long Term Disability, Retirement, Estate Planning & Life Insurance.

Olsten Kimberly QualityCare **#430**
710 Executive Park
Louisville, KY 40207
(502) 895-4213
Olsten HealthCare and Kimberly QualityCare are now one. With over 600 offices throughout the United States and Canada, OLSTEN KIMBERLY QUALITYCARE is not only the largest home health care provider in North America, but is committed to being the best. We provide a range of experienced health-care professionals from Companions to Registered Nurses, to Therapists and Medical Social Workers. Through our specialty programs including Infusion Therapy, Pediatric and Perinatal, Rehab and Vent, you can be assured your patient will receive the continuity of care that's essential in meeting your outcome goals.

Olympus America Inc **#216**
4 Nevada Drive
Lake Success, NY 11042-1179
(516) 488-0526
Olympus is featuring the EVIS 100 Video Endoscopy System with new 130 series videoscopes and ImageManager/EndoSpeak for image and data storage, retrieval, and report generation. Olympus also supplies a full line of endoscopy equipment including ultrasound endoscopes, enteroscopes, pediatric fiberscopes, Endo-Therapy accessories and ancillary products.

Ortho Pharmaceutical Corporation **#200**
Route 202
Raritan, NJ 08869
(908) 218-6943
Visit the Ortho-McNeil Pharmaceutical exhibit where representatives are prepared to discuss products and educational services of interest. Featured products include ORTHO-CERT™ (desogestrel/ethinyl estradiol), ORTHO-TRI-CYCLEN® and ORTHO-CYCLEN® (norgestimate/ethinyl estradiol). Also featured are ORTHO-EST®, TERAZOL®, and FLOXIN®.

Our Lady of Peace Hospital **#226**
2020 Newburg Road
Louisville, KY 40232
(502) 451-3330
Our Lady of Peace Hospital treats persons with emotional, behavioral, psychiatric, and addiction disorders. We offer short-term acute care programs for children, adolescents and adults. Treatment options include inpatient hospitalization, partial hospitalization (day treatment), and intensive outpatient (evening) programs, as well as a full range of outpatient counseling services at our six Peace Counseling Centers.

Pfizer Labs **#224**
14402 Willow Grove Circle
Louisville, KY 40245
(502) 244-7124

Physio-Control Corporation **#328**
11811 Willows Road, NE
Redmond, WA 98073
1-800-442-1142 ext 2618
Physio-Control Corporation manufactures the LIFEPAK® family of products, LIFEPAK 10P® LIFEPAK 9P® LIFEPAK® 300 automatic advisory defibrillator. Physio-Control is the world leader in defibrillation and non-invasive pacing technology with more monitor/defibrillators and non-invasive pacing products in service than any other manufacturer in the world. Our mission is to save lives. We do this by providing unique medical devices of the highest quality which predict or urgently intervene in live threatening, cardiorespiratory events. LIFEPAK® are the life saving tools for live saving teams.

The PIE Mutual Insurance Company **#416**
9300 Shelbyville Road, Suite 1001
Louisville, KY 40222
(502) 339-7431
The PIE Mutual Insurance Company of Cleveland, Ohio offers Kentucky physicians the advantages of an insurance program that has made it the leading professional liability carrier in Ohio. Owned and controlled by policyholders, the PIE is a nonprofit company whose innovative program features claims handling by a specialty law firm, physician participation in all areas of operations including peer review of all applicants, and rate stability that rewards loss-free physicians with scheduled premium reductions.

Pikeville Methodist Hospital **#233**
911 South Bypass
Pikeville, KY 41501
(606) 437-3500

Pratt-Pfizer **#125**
2400 West Central Road
Hoffman Estates, IL 60196-1082
(708) 765-9500

Ransdell Surgical, Inc **#210**
752 Barret Avenue
Louisville, KY 40204
(502) 584-6311
Ransdell Surgical, Inc has been distributing med/surg products to the health care market in Southern Indiana and Kentucky for the last 36 years.

Republic Bank & Trust Company **#415**
601 W Market Street
Louisville, KY 40202-2700
(502) 584-3600
Locally owned Republic Bank & Trust Company is the only bank exclusively endorsed by the Jefferson County Medical Society. Experienced banking officers will be on hand to present Republic services offered to medical professionals.

Rhone-Poulenc Rorer Pharmaceuticals Inc **#310**
500 Arcola Road
Collegeville, PA 19426
(215) 454-8246
Featured at our exhibit will be Lovenox® (enoxaparin sodium). Information on educational materials and other resources to benefit your practice will be available.

Roche Biomedical Laboratories **#435**
4010 Dupont Circle
Louisville, KY 40207
(502) 893-6319
Medical Laboratory testing services, serving physicians and hospitals in a 10 state area.

Roche Laboratories **#116**
340 Kingsland Street
Nutley, NJ 07110-1199
(102) 235-5000

Roerig/Pfizer **#228**
7312 Hunting Creek Drive
Prospect, KY 40059
(502) 228-0378

Ross Products Division of Abbott Laboratories **#418**
107015-RP32, 625 Cleveland Ave
Columbus, OH 43215
(614) 624-6449
Ross Products Division of Abbott Laboratories will be showing adult specialty nutritional products for patient's to insure adequate nutrition, vitamins and minerals. All products may be used with the flexiflo enteral delivery system or oral supplementation. We will also be sharing our service and educational items.

Saint Joseph Hospital **#402**
One Saint Joseph Drive
Lexington, KY 40504
(606) 278-3436
Saint Joseph Hospital, located in Lexington, is a tertiary treatment and referral center, serving the health care needs of central and eastern Kentucky. With 468 beds, Saint Joseph is the region's largest private, not-for-profit hospital, offering a full range of medical programs to meet community needs. Leading edge services include cardiology, cancer treatment, outpatient services and emergency care. Saint Joseph Hospital is an

affiliate of the Sisters of Charity of Nazareth Health System.

Saints Mary & Elizabeth Hospital **#308**
1850 Bluegrass Avenue
Louisville, KY 40215
(502) 361-6659
Literature will be distributed regarding hospital services, etc. Will also offer spot massages to include portable massage chair. Will distribute nice give-a-way.

Salcris Systems **#136**
800 Concourse Parkway
Birmingham, AL 35244
(205) 444-5400
Salcris Systems is undeniably "the computer people who treat doctors." This dynamic 15-year-old company is dedicated exclusively to the computer needs of physicians, clinics and hospitals. Salcris offers comprehensive medical office systems with remote office capabilities, timely software updates, Patient Scheduling, Medical Records and excellent collection features. Salcris is the leading firm in the Southeast. Ranked number one in Customer Satisfaction by an independent survey, Salcris Systems is dedicated to each and every need of your practice.

Schering Laboratories **#305**
2000 Galloping Hill Road
Kenilworth, NJ 07033
(908) 298-4000
Display of allergy, respiratory and dermatological products including nasal steroids, inhaled asthma medications and topical steroids (creams, ointments, lotions). Also our new once-a-day/non sedatins gel antihistamine-claritin.

Searle **#429**
5200 Old Orchard Road
Skokie, lL 60077
(708) 982-7000
Products to be displayed: Maxaquin® (lomefloxacin HCl); Calan® (verapamil HCl); Cytotec® (misoprostol); Daypro® (oxaprozin); and Ambien® (zolpidem tartrate)

SKYCARE **#100**
217 East Chestnut Street
Louisville, KY 40202
(502) 583-2444

Smith Barney **#412**
200 S 5th Street, Suite 100 N
Louisville, KY 40202
(502) 561-4012

SmithKline Beecham **#101**
4445 Lake Forest Drive, Suite 490
Cincinnati, OH 45242
(513) 733-5354
Our consultants will be on hand to answer your specific questions on our products and services.

SmithKline Beecham Clinical Laboratories **#313**
2277 Charleston Drive
Lexington, KY 40505
(606) 299-3866
Clinical Laboratory

Southeastern Group, Inc **#218**
(Blue Cross & Blue Shield)
9901 Linn Station Road
Louisville, KY 40223
(502) 423-2298

Ten Broeck Hospital **#426**
8521 LaGrange Road
Louisville, KY 40242
(502) 426-6380
Ten Broeck Hospital is located on beautiful park-like countryside which was formerly the home of the renowned Kentucky Military Institute. Ten Broeck is a 94-bed full service psychiatric & chemical dependency hospital offering inpatient & day treatment programs for children, adolescents, adults & the geriatric population. Our multi-disciplinary team includes psychiatrists, psychologists, social workers, psychiatric nurses, counselors & activity therapists all working together to provide a comprehensive treatment program for each patient.

3M Pharmaceuticals **#431**
3M Center, Bldg 275-3W-01
St Paul, MN 55144-1000
(612) 736-0079

UAD Laboratories **#417**
8339 Highway 18
Jackson, MS 39209
(601) 372-7773

Unico, Inc **#122**
125 N Weinback Avenue, Suite 230
Evansville, IN 47711-6506
1-800-926-3932
Unico, Inc is a regional dealer of The Medical Manager Office Management System. Unico, Inc can provide a complete system including software, hardware and all training. Our exhibit will contain a complete demonstration of The Medical Manager package. Electronic claims submission is available for Medicare, BC/BS, Medicaid, Humana, UMWA, and all major "Clearing Houses." Unico, Inc will be demonstrating a complete Manager Care System and Automated Collection Module.

United States Air Force **#437**
2515 Perimeter Place Drive
Nashville, TN 37214-3671
(615) 889-0723
Recruitment of Physicians

University of Kentucky Chandler Medical Center **#421**
800 Rose Street
Lexington, KY 40536-0084
(606) 323-5000
The physicians practicing at UK Hospital and Kentucky Clinic are committed to meeting the consultation and referral needs of physicians throughout the Commonwealth. Comprehensive services include cancer and cardiac specialties, neurosciences, obstetrics and gynecology, and pediatrics. The 473-bed hospital offers Level I trauma care, organ transplantation, neonatal intensive care, magnetic resonance imaging, and multidisciplinary programs. Visit our booth to learn more about our physician access services, including the UK-MDs physician-to-physician 800 number.

Wyeth-Ayerst Laboratories **#201**
PO Box 8299
Philadelphia, PA 19101
(610) 971-2782
Wyeth-Ayerst welcomes the opportunity to continue their longstanding association with the Kentucky Medical Association through participation in your exhibit program. Our professional representatives will welcome the opportunity to visit with you and discuss any inquiries you may have concerning our products including Premarin,® Lodine® 400, Oruvail®.

Zeneca Pharmaceuticals Group **#433**
1800 Concord Pike
Wilmington, DE 19897
1-800-441-7758

Medfax Corporation **#121**
South Lake Office Park
Tega Cay Road
Fort Mill, SC 29715
(803) 548-1502
Medfax Corporation works exclusively with medical clients to develop and support state-of-the-art turn-key medical computer systems. There are over 3500 physicians using Medfax software. Modules include billing, insurance processing, electronic claims and remittance, appointment scheduling, collections, reporting, medical records, managed care module, report writer, A/P, G/L, P/R, word processing, spreadsheet, etc.

Med-Systems Management, Inc **#404**
7426 North Dixie Drive
Dayton, OH 45414
1-800-233-8989
The future billing systems will be Computer-Based Medical Record Systems that will network provider, payors, and employers. Legislative action to create a capitated reimbursement system is advancing the obsolescence of current billing systems. Med-Systems Management, Inc has a state-of-the-art system designed to migrate through the capitated environment to the computer based medical record. This system will provide the outcome results required by all payors, employers, patients and government agencies.

Norton Psychiatric Clinic **#330**
200 E. Chestnut Street
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(502) 629-8850
For nearly 50 years the Norton Psychiatric Clinic of the Norton Hospital has provided comprehensive psychiatric care in a medical setting. In addition to the 48-bed inpatient service, a wide range of mental health services are available. These services include partial hospitalization and satellite offices located throughout the metropolitan Louisville area. The clinic offers innovative treatment including cognitive-behavioral therapy provided by a team of mental health professionals. The full medical resources of the Norton Hospital are available for those clients who have medical and psychiatric disorders. The clinic is associated with the University of Louisville School of Medicine Department of Psychiatry.

Southern Medical Association **#109**
35 Lakeshore Drive
Birmingham, AL 35209
(205) 945-1840

The Upjohn Company **#408**
600 Vine Street, Suite 2704
Cincinnati, OH 45202

AN INVITATION

For a chance to visit with your Annual Meeting Exhibitors, join us each morning (Tuesday, Wednesday, & Thursday) in the Lounge area, located in the center of the Commonwealth Convention Center Exhibit Hall, from 8:15 am - 9:00 am, for free coffee & danish.

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates to KMA members: $10 per insertion up to 50 words, 25¢ each additional word. To non-members; $30 per insertion up to 50 words, 25¢ each additional word.

Send advance payment with order to: The Journal of KMA, 301 N Hurstbourne Pky, Ste 200, Louisville, KY 40222.

PA/NP RECRUITMENT ASSISTANCE — The University of Kentucky Medical Professions Placement Service now offers assistance in the recruitment of physician assistants and nurse practitioners in addition to physician placement. Qualified candidates possessing a variety of backgrounds and experience are available. For more information on how we can help you, please contact: Beth Shedd, UKMPPS, 202 H.S.L.C., Lexington, KY 40536-0232, phone 606-323-6842/800-288-0658.

OFFICE FOR RENT OR FOR SALE — Franklin, KY, 20 miles south of Bowling Green, KY, and 40 miles north of Nashville, TN. Office fully equipped. Good location across from hospital. Contact Dr D. Alvey 502/586-6114 or 586-6075.

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Danny M. Clark, MD Nominated for KMA President-Elect

Danny M. Clark, MD, has been nominated by the Pulaski County Medical Society for the office of President-Elect of the Kentucky Medical Association.

An obstetrician-gynecologist in Somerset, Dr Clark has been diligent in his many years of dedicated service to organized medicine. He is a past President of the Pulaski County Medical Society and has been a member of the Kentucky Board of Medical Licensure since 1986. From 1974 until 1980 he served as an Alternate Trustee and from 1980 until 1986 as a Trustee for the Kentucky Medical Association. Dr Clark was elected Vice Speaker of the KMA House of Delegates in 1986 and served in that capacity until 1990 when he was elected Speaker, the position he currently holds.

A native of Paris, Kentucky, Dr Clark received his undergraduate degree from Transylvania University in 1958 and his medical degree in 1962 from the University of Cincinnati.

Following completion of an internship and residency at Los Angeles County General Hospital from 1962 until 1967, Dr Clark served as a Captain in the United States Air Force for 2 years. Since 1969, he has been in a private OB-GYN practice in Somerset, where he has privileges at Somerset City Hospital and Humana Hospital Lake Cumberland.

Dr Clark and his wife Joyce, who is currently serving as President of the Kentucky Medical Association Alliance, have five children and six grandchildren.



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Please notify us at least two months in advance.

Send new address to:

Journal of the Kentucky Medical Association
301 N Hurstbourne Pkwy, Suite 200
Louisville, KY 40222-8512

CAGE
Questionnaire

For the Diagnosis of Alcoholism

C = Have you ever felt you should **cut down** on your drinking?

A = Have people **annoyed** you by criticizing your drinking?

G = Have you ever felt bad or **guilty** about your drinking?

E = Have you ever had a drink first thing in the morning (**eyeopener**)?

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Positive CAGE Answers:

1 = Suggestive 2 = Probable 3 and/or 4 = Diagnostic

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Committee on Impaired Physicians
301 N Hurstbourne Pky, Ste 200
Louisville, KY 40222-8512
(502) 426-6200

Audubon Regional Medical Center Office Building

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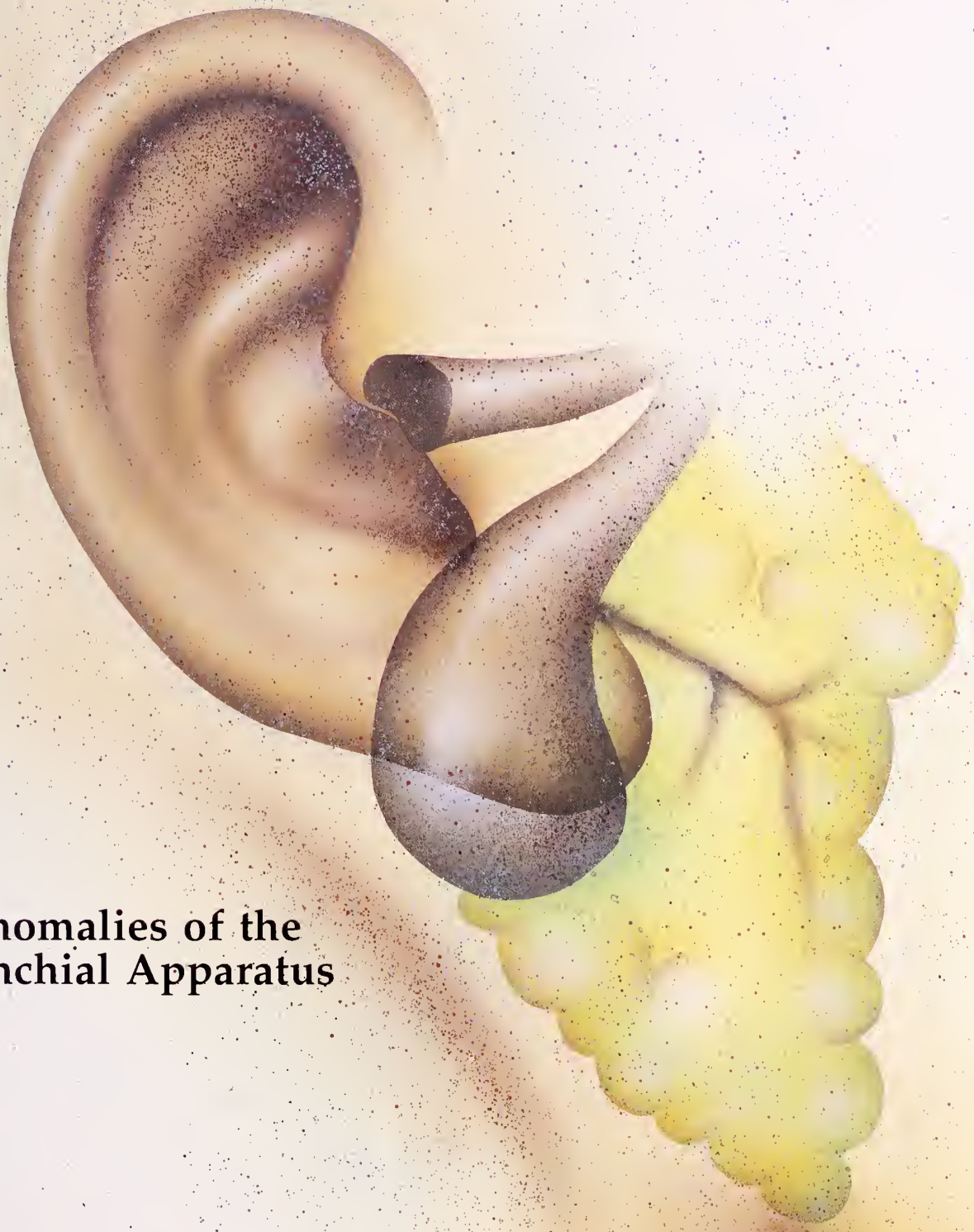
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Anomalies of the Branchial Apparatus

SEPTEMBER 1994
VOLUME 92, NUMBER 9

"

FIRST YOUR KID WRECKS THE **CAR.**
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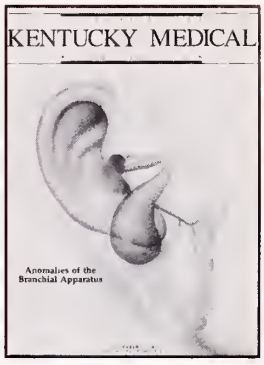
JOURNAL OF THE

KENTUCKY MEDICAL

ASSOCIATION

VOLUME 92, NUMBER 9 SEPTEMBER 1994

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COVER: Illustration by Lee Wade of Louisville introduces an article on anomalies of the branchial apparatus. See page 358.

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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Second-class postage paid at Louisville, KY and additional offices. Yearly subscription rates: $25 domestic; $30 foreign. Single issues $3 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association*, 301 N Hurstbourne Pkwy, Suite 200, Louisville, KY 40222-8512. EDITORIAL AND ADVERTISING: Telephone 502/426-6200.

Listed in Index Medicus. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

National advertising representative: State Medical Journal Advertising Bureau, Inc, 11437 W 106th St, Overland Park, KS 66214, phone 800/788-2360.

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Ardis D. Hoven, MD

"The Final Round"

"Having moved this far in the process, having committed to follow the mandate of the KMA House of Delegates, and having heard your concerns regarding this issue, we will now proceed to the federal level."

My year serving as President of the Kentucky Medical Association is rapidly coming to a close and with it the resolution of certain issues, but the emergence of new problems impacting on the delivery of health care in this state. Concurrently, the debate on health systems reform at the national level is at high intensity with numerous bills and currently no consensus. This demands that we pay close attention, that we interact with our elected officials, and most importantly, that we interact with and educate our patients.

At home, the provider tax litigation will be taking the final step in the petition for writ of certiorari by the United States Supreme Court. We shall challenge the issues of due process and the procedural aspects of the appointments of the special justices. I personally feel that this is clearly the proper step to take. Having had the opportunity to travel the entire state and discuss the issues with my peers, I feel committed to pursue this action, as does your Board of Trustees. However, the argument can strongly be made that perhaps the cost of this entire litigation process outweighs the benefits — the success of winning such a challenge is considered to be severely limited. Nonetheless, having moved this far in the process, having committed to follow the mandate of the KMA House of Delegates, and having heard your concerns regarding this issue, we will now proceed to the federal level.

The next phase of health systems reform in Kentucky is currently underway with the delineation of administrative regulations for House Bill 250. We have been assured by the Secretary for CHR that we will have ample early opportunity to interact with government in writing these regulations and to testify at public hearings.

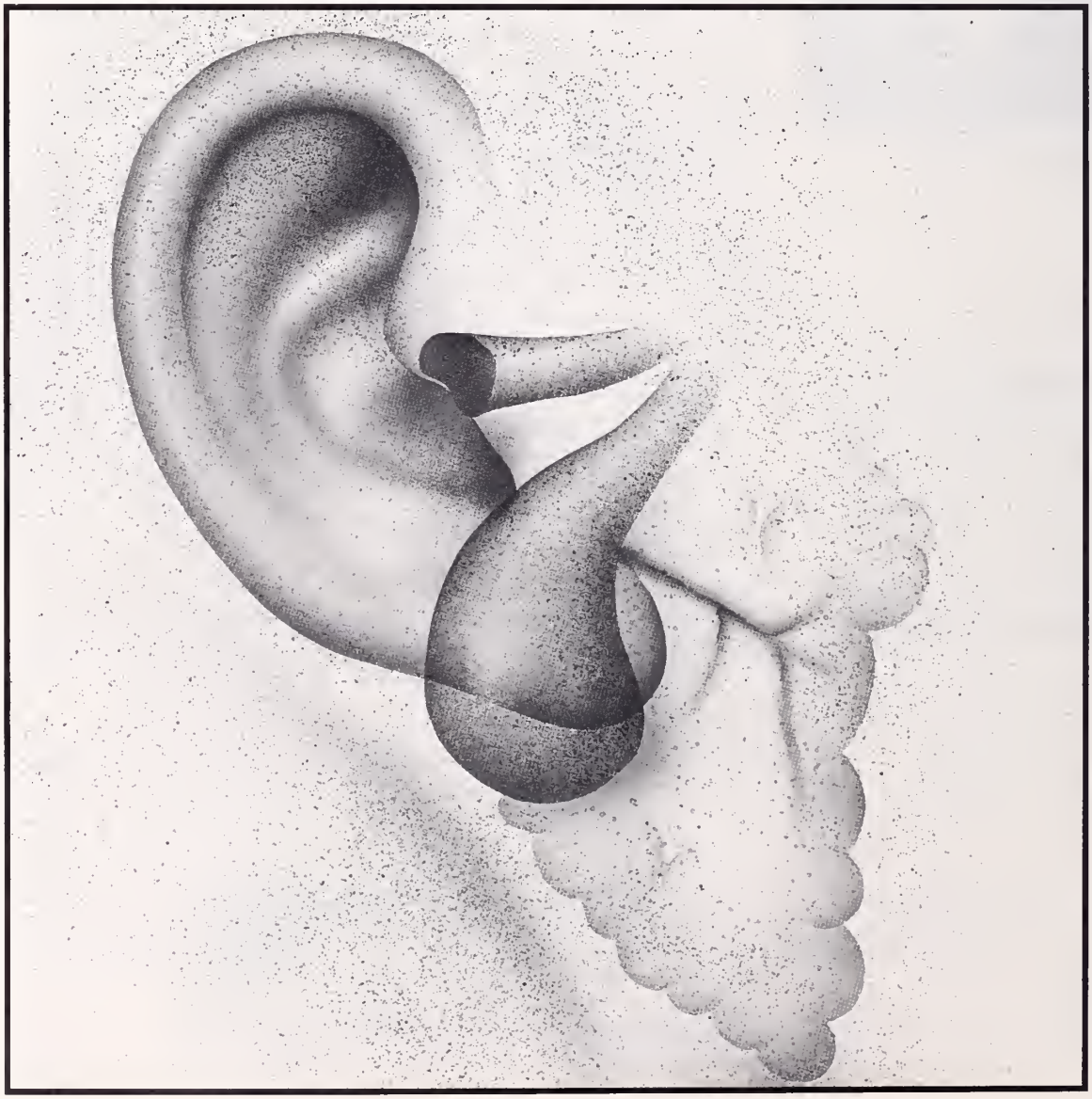
Medicaid problems continue — in terms of provider reimbursement ($50 million reduction to physician providers) — along with potential new and creative ways to mold Medicaid patients, KENPAC patients, and other groups of patients into managed care programs. This behooves us to be prepared and to have in place, at least conceptually, the mechanisms by which taking care of these patients can be achieved, either statewide or regionally. This requires that we become managed care experts — like it or not! Those educational initiatives are underway, and I encourage you to avail yourself of this information through the KMA headquarters.

Membership in KMA increases daily and speaks strongly in support of the efforts of organized medicine. Please continue your support and work with us to expand the membership and the level of participation of all physicians in the Commonwealth who care about patients and the delivery of high quality, cost effective health care.

Ardis D. Hoven, MD
KMA President

Anomalies of the Branchial Apparatus: A Case Report and Review of Embryology, Anatomy and Development

T. Oma Hester, MD; Raleigh O. Jones, MD; Richard C. Haydon, MD



The majority of congenital anomalies occurring in the neck are related to the development of the branchial apparatus. This area is responsible for the development of multiple structures in the head and neck and thus its anatomy and embryology are complex. Although cysts, sinuses, and fistulas of the branchial region are not common occurrences, they do present in a variety of settings and are generally easily managed if diagnosed early. A fundamental understanding of their anatomy, embryology, and presentation is needed to appropriately diagnose and manage them. These fundamentals are reviewed and a case report is used to illustrate one of the more common presentations.

Most congenital anomalies of the head and neck are attributed to the transformation which the branchial apparatus undergoes in the process of its development. Because of its complex embryology and the infrequency with which anomalies occur in this region, the branchial apparatus has long been confusing and difficult for students and practitioners alike. An understanding of the anomalies that occur in this region is further complicated by the lack of a single body of evidence and thought describing their developmental history. Despite these difficulties, congenital sinuses and cysts of the head and neck region evolving from the branchial apparatus are a point of clinical interest and can be easily and effectively managed once diagnosed. We present a case of an anomaly originating in the second branchial sinus and review the fundamental embryology, presentation, and management of other congenital branchial anomalies.

Case Report

A 3½-year-old girl presented with a history of a small draining area on her neck. The mother stated that the small dimple had been present since birth and had drained several drops of mucoid material daily since birth. There was currently no evidence of infection or history of infection and the amount of drainage had been fairly constant without signs of worsening.

On physical examination, the child appeared within the normal limits of size for her age. She was afebrile and in no apparent discomfort. She had moderate tonsillar enlargement without signs of acute infection and her heart and lungs were clear. There was a 2-3mm pit in her lower right neck anterior to the sternocleidomastoid (SCM) near the bifurcation of the sternal and clavicular heads. The rest of her neck exam revealed no masses or adenopathy and the results of her physical exam and laboratory studies were also normal.

A preoperative fistulogram was obtained (Fig 1). It revealed a fistulous tract extending from the lower right neck to the area of the right tonsillar fossa. A complete surgical excision was planned. Under general anesthesia, a 2Fr Fogarty catheter was introduced into the skin pit and threaded forward until the tip of the catheter was seen in the oropharynx in the region of the inferior anterior tonsillar pillar. This technique demonstrated the presence of a 9 cm fistulous tract extending from the inferior anterior tonsillar pillar to the skin just anterior to the clavicular third of the SCM. The tract was removed in its entirety through two small horizontal skin incisions. Meticulous dissection was used to avoid injury to the superior laryngeal, vagus, and hypoglossal nerves. There

From the Division of Otoloryngology-Heod & Neck Surgery, Deportment of Surgery, University of Kentucky Medicol Center, Lexington, KY. Reprint requests to Dept of Surgery, Division of Otoloryngology-Heod & Neck Surgery, Room C236 UKMC, Lexington, KY 40536-0084 (Dr Jones).

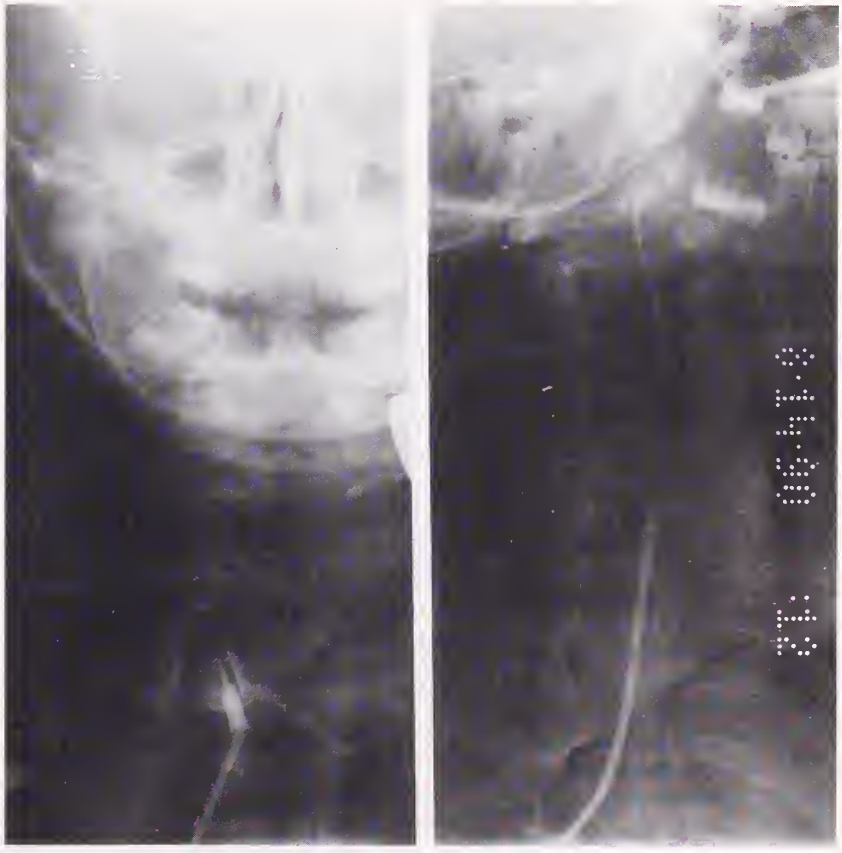


Fig 1 — Preoperative fistulogram.

were no complications and the child has continued to do well postoperatively.

Embryology

The branchial apparatus undergoes its initial development between the third and seventh weeks of fetal life. Initially, a group of four endodermally lined pouches appears within the lateral wall of the primitive foregut, while a series of ectodermally lined clefts is developing opposite and in close approximation to the pouches. Five paired mesodermal pharyngeal arches, each supplied with its own artery and nerve, separate these pouches and clefts. Each arch develops into well-defined skeletal muscle and connective tissue structures in the fully developed fetus. The clefts and pouches give rise to a variety of other anatomic structures (Table 1). Mesodermal proliferation within the arches and the subsequent development of the various branchial derivatives should result in the obliteration of each pouch and cleft space (except for the first, which persists as the external auditory canal and eustachian tube). If these spaces are not completely obliterated, a remnant may persist in the form of a cyst, sinus, or fistula. Although these lesions are uncommon, a knowledge of their embryologic development and respective presentations is necessary to be able to readily diagnose and treat them.[1,2]

Table 1. Derivatives from the branchial apparatus. (From Donegan, JO. Congenital neck masses, in Cummings (ed) Otolaryngology-Head and Neck Surgery, CV Mosby, 1986, p. 1598.)

Ectoderm	*Mesoderm*	*Endoderm*
First cleft	**First arch**	**First pouch**
External auditory canal	Mandible and teeth, Meckel's cartilage	Eustachian tube
Tympanic membrane	Muscles of mastication, tensor tympani muscle, and anterior belly of digastric muscle	Tympanic cavity
	Malleus and incus; external maxillary artery	Mastoid antrum and cells
	Fifth cranial (trigeminal) nerve	Tympanic membrane
	Middle layer of tympanic membrane	
Second cleft	**Second arch**	**Second pouch**
Cervical sinus of His (epidermis of anterior cervical triangle)	Platysma, muscles of facial expression, and posterior belly of digastric muscle	Palatine tonsil
	Stapedial artery	Supratonsillar fossa
	Body and lesser horns of hyoid	
	Stylohyoid ligament	
	Seventh (facial) and eighth (acoustic) cranial nerves	
	Styloid process and stapes; stapedius muscle	
Third cleft	**Third arch**	**Third pouch**
Cervical sinus of His	Superior constrictor muscles	Interior parathyroid
	Internal carotid artery	Thymus reticulum
	Ninth cranial (glossopharyngeal) nerve	Piriform fossa
	Greater horns and body of hyoid	
Fourth cleft	**Fourth arch**	**Fourth pouch**
Cervical sinus of His and epidermis of lower neck	Part of epiglottis	Superior parathyroid
	Thyroid and cuneiform cartilages	
	Tenth cranial (vagus) nerve	
	Aortic arch and right subclavian artery	
	Inferior constrictor and laryngeal muscles	
	Sixth arch	
	Part of laryngeal muscles	
	Corniculate, arytenoid, and cricoid cartilage	
	Eleventh cranial (spinal accessory) nerve	
	Ductus arteriosus	

Clinical Presentation

Branchial remnants can occur as cysts, sinuses, or fistulas. Morphologic and age differences are reflected in the various presentations. Branchial anomalies are classified by the arch (I-IV) to which they are related.

Branchial cysts typically appear as a smooth, round, mobile mass with an anatomic location between the tragus and clavicle anterior to the SCM. The most common age at presentation is between the second and fourth decade; sex distribution is equal, although there have been reports of a hereditary predilection. Some presentations may be preceded by a bout of pharyngitis, neck abscess, otitis, or upper respiratory infection. Cysts are usually asymptomatic, although large cysts may cause discomfort and can disrupt normal pharyngeal or laryngeal function.[3]

Branchial sinuses and fistulas generally are evident in the neonate and are more common in females. These present as an external skin pit in the lower third of the anterior neck and are bilateral in 30% of cases.[4] Most commonly, these lesions will secrete a small amount of mucoid material, which may become purulent during occasional bouts of infection.

First Branchial Cleft: Anomalies of the first branchial cleft are classified into two major types (Fig 2). They account for less than 10% of all branchial cleft anomalies.[5] Their presentation is characterized by varying degrees of atresia, stenosis, or reduplication of the external auditory canal (EAC). Type I anomalies are rare and represent a duplication of the membranous portion of the EAC. Generally, these present as a cystic mass in the periauricular area that extends medially and anteriorly along the EAC. Infection may lead to spontaneous drainage resulting in an external opening.

Type II lesions are more common and may present earlier in childhood. These lesions consist

of a duplication of the membranous EAC and the pinna with a tract extending medially or laterally to the facial nerve. Type II lesions may present with a fistula in the concha or EAC or with a lesion in the anterior triangle inferior to the angle of the mandible. Before surgical treatment, it is important to determine the proximity and degree of association of these lesions to the parotid gland and facial nerve.[6]

Second Branchial Cleft: Remnants of the second region are certainly the most common source of branchial lesions, which may be bilateral in up to one third of cases. Cysts of the second cleft usually are deep to the anterior border of the SCM at the level of the angle of the mandible. Sinuses and fistulas are deep to the platysma, extending along the anterior border of the SCM, and may have an opening near its lower anterior edge. The sinus tract extends superiorly between the second and third arch derivatives ascending with the carotid sheath. Passing laterally to the superior laryngeal and hypoglossal nerves, the tract turns medially to pass over the glossopharyngeal nerve and between the internal and external carotid arteries, ending near the middle constrictor. Commonly, the tract may have an opening in the tonsillar fossa (a second arch derivative), as demonstrated in our case[7,8] (Fig 3).

Third Branchial Cleft: Anomalies of the third branchial region are extremely rare but are similar to those of the second branchial sinus in their external opening and initial direction of ascent. Higher in the neck, however, this tract continues posteriorly to the glossopharyngeal nerve and internal carotid artery, then turns inferiomedially to pass over the superior laryngeal and hypoglossal nerves, before piercing the thyrohyoid membrane and opening into the ipsilateral pyriform sinus[9] (Fig 3).

Fourth Branchial Cleft: Although once discussed only in theory, the fourth branchial remnant is being more frequently described.[10,11] Again, this lesion may present as a sinus tract in the anterior cervical triangle but would then pass inferiorly to the aorta (for lesion on the left) or the subclavian artery (right) diving into the upper mediastinum. From there, the tract may follow the recurrent laryngeal nerve ascending to enter the esophagus. Although this lesion is certainly rare, it should be considered a possible causal factor in cases of recurrent neck abscess or acute suppurative thyroiditis. These lesions occur most frequently in children and are predominantly left-sided.[10,11]

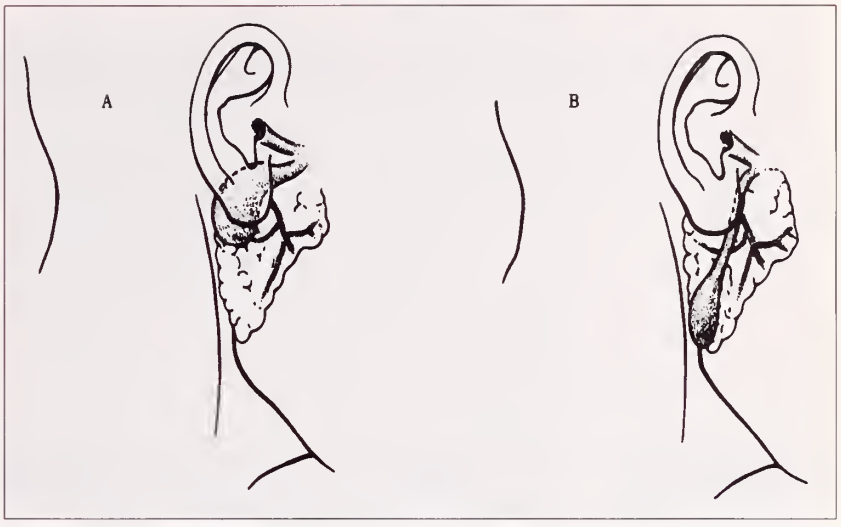


Fig 2 — Type I (A) and Type II (B) first branchial anomalies. (From Donegan, JO. Congenital neck masses, in Cummings (ed) Otolaryngology-Head and Neck Surgery, CV Mosby, 1986, pp. 1599-1600.)

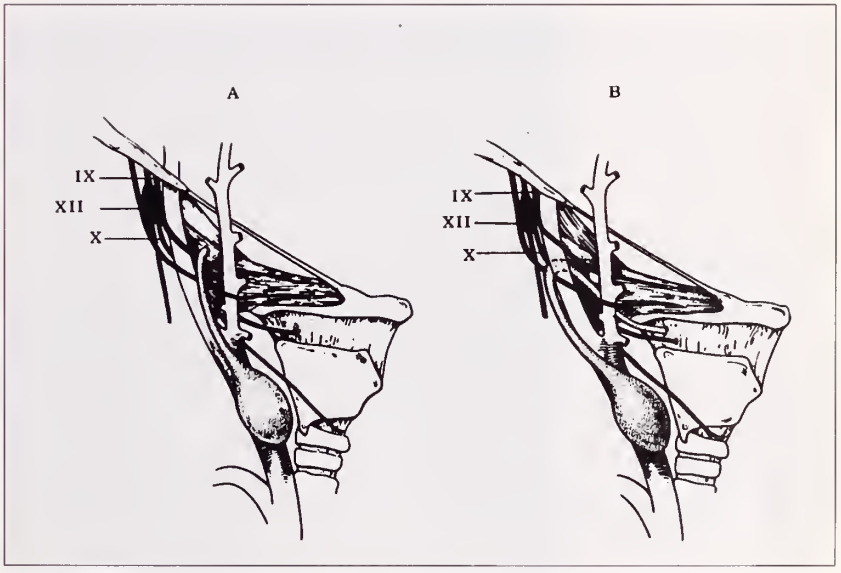


Fig 3 — Anatomy of second (A) and third (B) branchial defects. (From Donegan, JO. Congenital neck masses, in Cummings (ed) Otolaryngology-Head and Neck Surgery, CV Mosby, 1986, p. 1601.)

Discussion

The preferred treatment for branchial anomalies is total surgical excision. Preoperative evaluation should include the search for contralateral branchial defects and other congenital anomalies. Radiologic evaluation with radiopaque dye is often useful and warranted. Attempts to cannulate a sinus tract should be withheld until the time of operation when a small catheter, lacrimal probe, or methylene blue can be used to aid in following the tract. For lesions in the newborn, delaying excision until the child is several years old may be warranted. Optimally, excision can be done early before the occurrence of secondary infection(s). A tract that has been infected will be more difficult to excise and will require more meticulous dissection and possibly wider margins of excision. Inadequate excision of the epithelial tract leads to recurrent infection and even more difficult surgical management.

Recurrences are more likely in cases of sinus lesions than in cystic lesions, but reported rates vary from 5% to 20%. The most important factor leading to recurrence of a lesion is the history of prior infection. Other complications involve injury to surrounding structures, mainly the trigeminal, facial, glossopharyngeal, vagus, spinal accessory, and hypoglossal nerves and the carotid system.

Conclusion

Most congenital lesions of the head and neck region are attributed to the abnormalities in the development of the branchial apparatus region. Although uncommon, such anomalies are intriguing and warrant the attention of clinicians and surgeons. The most common presenting symptom of branchial sinuses is a small supraclavicular skin pit that drains mucoid material. Other presentations may be associated with pharyngitis, retropharyngeal abscess, or otitis. Patients may suffer an unresolving prolonged course of recurrent neck infections prior to the diagnosis of such anomalies, but once diagnosed, treatment is relatively benign and effective. Successful diagnosis relies on knowledge of the embryology and anatomy of this region as well as knowledge of the location and common presentations of such lesions.

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Unusual Presentation of a Secondary Malignancy with an Unknown and a Known Primary Malignancy

Pran M. Kar, MD; George R. Aronoff, MD; Thomas M. Woodcock, MD

This is a report of two interesting cases of a secondary malignancy with an unusual presentation with an unknown and a known primary cancer.

Case 1 —

A 77-year-old white female was admitted to the hospital with chief complaints of progressive shortness of breath, with no sputum production prompting intubation. She gave a history of decreased urine output and had not urinated for 6 hours prior to her hospital admission. She had a past medical history of well-controlled hypertension for which she was taking enalapril, and had a 40-pack-year history of smoking.

On examination, the patient was awake, alert, and intubated. Her blood pressure was 170/80 mm of mercury with a pulse rate of 120 beats and a respiratory rate 45 bpm. Positive physical findings on examination were the presence of bilateral crackles on auscultation of the chest and no palpable femoral pulse on the left side.

Laboratory data: BUN 51 mg/dl, creatinine 3.5 mg/dl. Protein C and S were within normal limits.

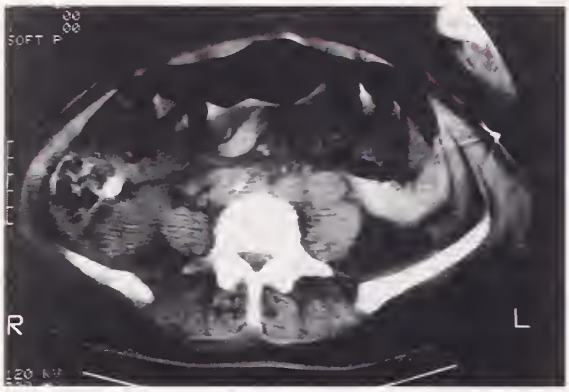
Radiological data: Chest roentgenogram showed evidence of bilateral pulmonary edema (Fig 1). A computed tomography (CT) scan of the abdomen and pelvis (Figs 2 and 3) showed a soft tissue fullness over the upper left iliac artery region possibly representing adenopathy or focal edema measuring approximately 3 to 4 cm in diameter. CT scan of head and chest were unremarkable. 2D echocardiogram showed mild left ventricular hypertrophy. Renal ultrasound revealed that the kidneys were normal size bilaterally with no evidence of obstruction. Renal scan with technetium DPTH showed significantly diminished left renal blood flow compared to the right side. A request to do renal angiogram was declined by the patient and her family.

Hospital course: Patient underwent an emergency thrombectomy and was started on hemodialysis for fluid overload and was extubated within 24 hours of admission. She continued to remain anuric and required hemodialysis as part of her

From the Division of Kidney Diseases and Medical Oncology, Department of Medicine, University of Louisville, Louisville, KY.



Figure 1 — Extensive bilateral infiltrates and pulmonary edema.



Figs 2 and 3 — CT scans showing a soft tissue fullness over upper left iliac artery region.

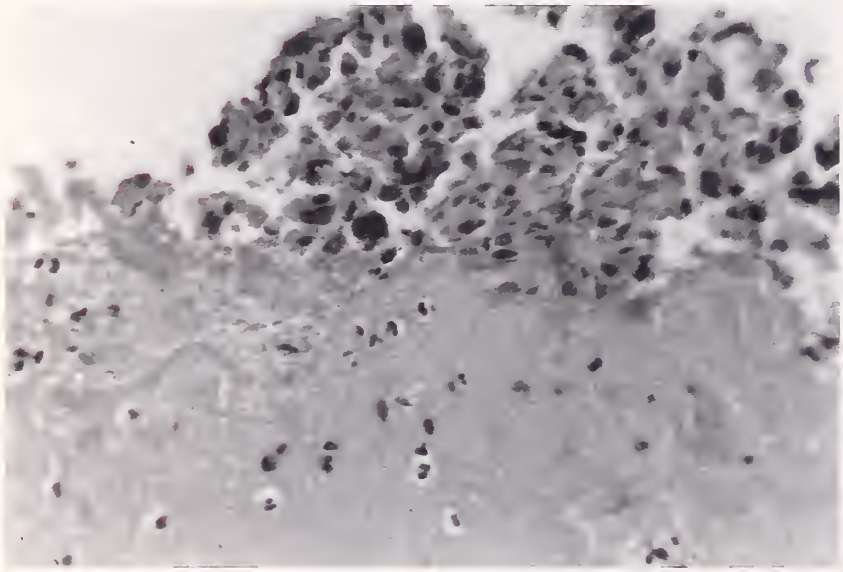


Fig 4 — Microscopic sections of the blood clot reveal laminated fibrin and cellular elements. Within the blood clot are large epithelioid cells with malignant cytologic features suggesting a poorly differentiated carcinoma.

renal replacement therapy. She had unexplainable episodes of shortness of breath and intermittent confusion with complete resolution. Her condition continued to deteriorate and, at the request of the patient and family, hemodialysis was discontinued. The patient died within 48 hours of discontinuation of this therapy.

Pathology of the blood clot from the thrombectomy revealed clusters of large epithelioid cells with malignant cytologic features suggesting a poorly differentiated carcinoma (Fig 4). Immunoperoxide stain for cytokeratin and epithelial marker was strongly positive, suggesting vascular thrombosis associated with neoplasia (Fig 5).

Case 2 —

A 70-year-old white male presented to his primary physician with rectal bleeding. Sigmoidoscopy revealed a cauliflower lesion, and the patient was referred to a surgeon. He had a past medical history of well-controlled hypertension for which he was taking methyldopa and propanolol daily. The only positive physical finding on examination was a palpable, fixed nontender 2 cm mass on his penis.

Hospital course: Patient had a resection of his abdominal carcinoma and a biopsy of the penile lesion. He was discharged and started on radiation and chemotherapy as an out-patient. Nine months after the initial diagnosis, the patient expired.

Pathology of the resected abdominal mass was found to be adenocarcinoma (Fig 6). The penile biopsy revealed metastatic adenocarcinoma consistent with colonic origin (Fig 7).

Discussion

Cancer accounts for 22% of all deaths, with lung carcinoma being the most common form of cancer in this country.[1] Five to 10% of all cancer patients have an unknown primary.[2] Forty percent of lung cancers have metastatic disease on initial presentation.[2] These metastatic tumors can spread through the arterial system by embolization. Atrial myxomas cause 45% of all reported arterial tumor embolization; metastatic pulmonary rather than primary lung cancer account for the rest. The two most common sites are lower extremity (42%) and cerebral vessels (28%).[5]

The mechanism of metastases of cancer cells is by the invasion of blood vessels, followed by the transport of tumor cells by established vascular pathways, attachment, and then growth of the

embolic cancer cells at the distant site, assisted by disseminated intravascular coagulation and a hypercoagulable state. The tumor emboli is more likely to attach and invade an already damaged vessel wall.[3,4,5]

Our first patient probably had a pulmonary malignancy, which may not have been diagnosed due to the fact that she did not have a bronchoscopy or lung biopsies. An atrial myxoma was ruled out by the normal 2D echocardiogram. Her episodes of shortness of breath and confusion were attributed to be the results of showers of pulmonary[7,8,9] and cerebral[3] emboli. What we cannot explain is the complete resolution of these symptoms with a normal CT scan of her head and chest and the findings on her CT scan of her abdomen.

To the best of our knowledge, there has been only one reported case of tumor emboli in the superficial femoral artery, where the primary source, a malignant melanoma, became obvious 5 months after the embolic event.[6]

Our second patient's metastatic lesion to his penis was discovered by an astute physical exam. Literature review documents that the penis is a rare site for metastasis, and only 200 cases have been reported despite the rich vascularization and complex circulation in the area. The patient usually presents with a nodularity, ulceration, swelling, hematuria, or obstruction. The cancer spreads rapidly by direct extension, venous or lymphatic spread, and even arterial embolization. The prognosis of metastatic cancer to the penis is extremely poor, with more than 80% of patients dying within 6 months.[10,11] Our patient survived for a longer than average period of time.

In conclusion, we concur with Karamchandani et al that a pathologic examination of all embolic material should be performed, and special emphasis given to a thorough physical exam.

ACKNOWLEDGMENTS: We would like to thank Drs James Beattie, Marie Michelson, and Steven Smith for their assistance in preparing this paper.

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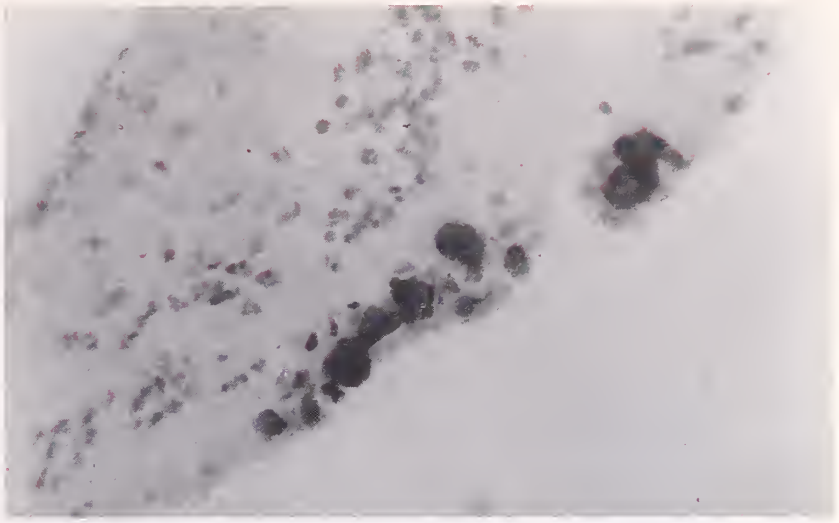


Fig 5 — Microscopic section of blood clot with immunoperoxidase stain, strongly positive for cytokeratin.

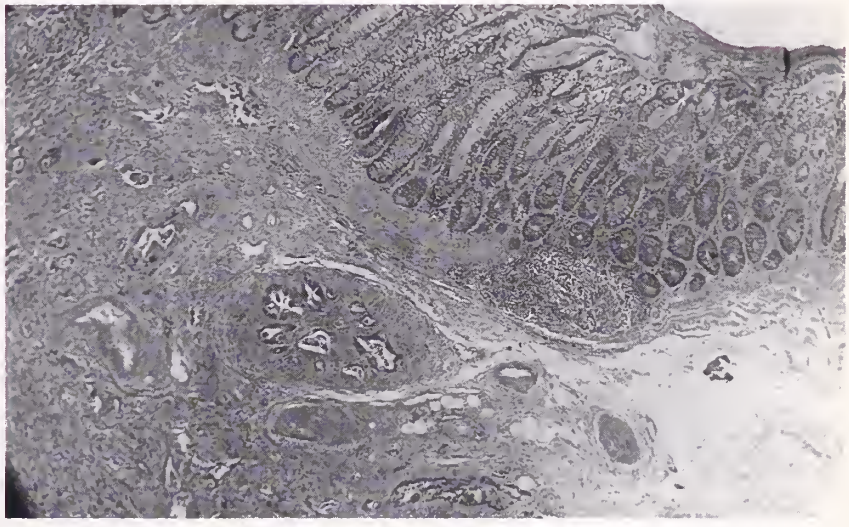


Fig 6 — Section of colonic mucosa covered with glands lined by a single layer of tall columnar mucin secreting epithelium (40 × magnification). In the submucosa are nests of irregular malignant cells with large hyperchromatic nuclei.

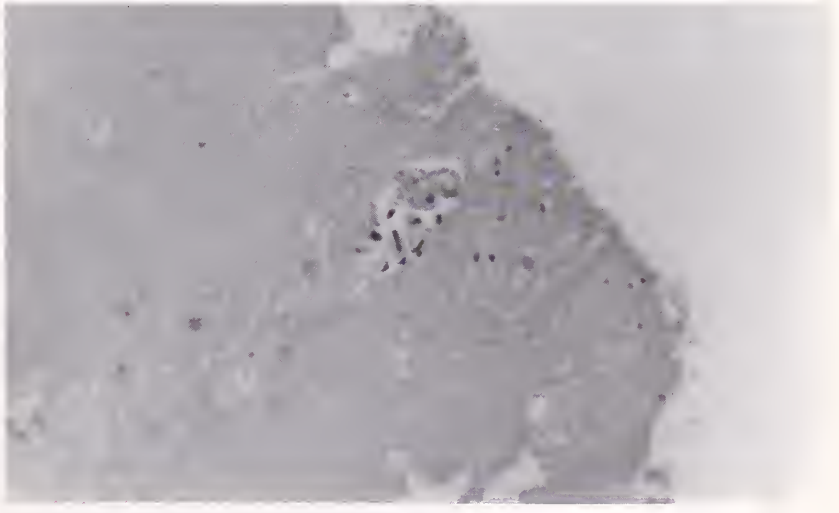


Fig 7 — Section of penis showing irregularly glandular structures lined by a single to pseudostratified layer of tall columnar epithelial cells with large irregular hyperchromatic nuclei, with numerous mitosis. Tumor cells are noted in vascular spaces. Tumor is similar to that seen in the colon biopsy (Magnification 400X).

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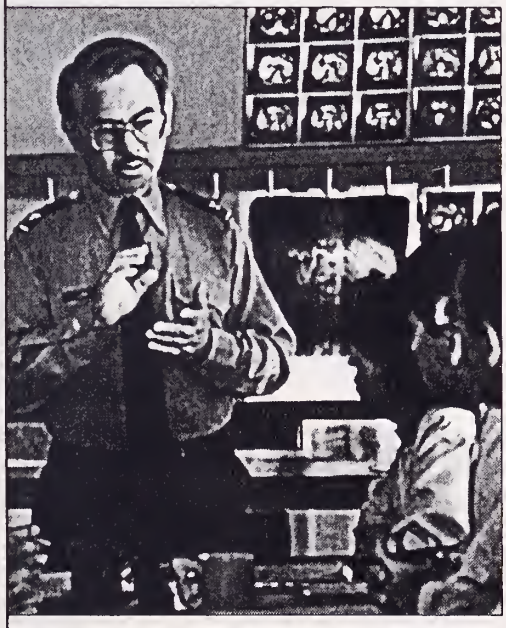


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Kidney and Pancreas Transplantations in Kentucky: An Option Whose Time Has Come!

Jon W. Jones, MD; Solly S. Mizrahi, MD; Frederick R. Bentley, MD

From the Department of Surgery, University of Louisville School of Medicine, Louisville, KY.

Reprint requests to Department of Surgery, Editorial Office, University of Louisville, Louisville, KY 40292 (Dr Jones). Phone 502/852-1727.

Pancreas transplantations are being performed in the United States with increased frequency each year. At the 53 kidney and pancreas transplant centers across the United States, an average of 400 pancreas transplants in combination with kidney transplants (ie, simultaneous) have been performed per year. As of November 1992, there has been a total of 2,061 combined kidney-pancreas transplants performed in the United States (Fig 1). Patients with end-stage renal disease secondary to insulin-dependent diabetes mellitus, who are either waiting for or are on dialysis, are candidates for the combined transplant.

Pancreas transplantations alone are performed much less frequently than combined transplants due to the controversy regarding the benefit of transplantation *versus* the risk of immune suppression. In those diabetic patients who also require a kidney transplant, the surgeon must weigh the risk of immune suppression versus the benefit of pancreas transplantation.

Pancreas transplantation alone and in combination with kidney transplantation was first attempted in the late 1970s. At that time, pancreas transplantation had a much lower rate of success than kidney transplantation. The success rate has since improved because of current ability to the measure urine amylase, which is a marker for rejection that is obtained from bladder drainage of the pancreas via a duodenocystostomy. The current pancreas graft survival rate is approximately 80% for the first year, which is equivalent to the survival rate of other solid organ transplants. Historically, it was not until the late 1980s, when cyclosporine was in common use for immune suppression, that the 1-year survival for a combined procedure reached about 50%.

The pancreas transplant program at the University of Louisville began in 1986. Currently, the University of Louisville has the only pancreas transplant center in the State of Kentucky.

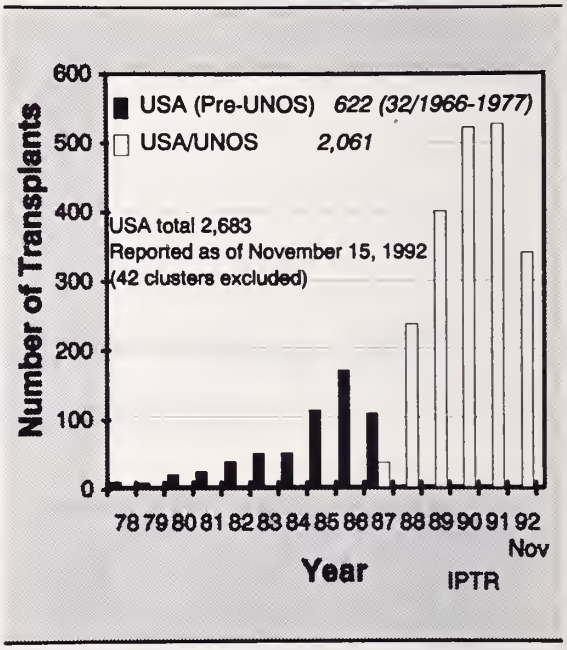


Fig 1 — Data fram the UNOS Pancreas Transplant Registry as reported in Clinical Transplants 1992. (Reprinted with permission from Sutherland DER, Gruessner A, Moudry-Munns K. Analysis af United Netwark far Organ Sharing (UNOS) United States af America (USA) Pancreas transplant registry data accarding ta multiple variables, In: Terasaki PI, Cecka JM, eds. Clinical Transplants 1992. Las Angeles: UCLA Tissue Typing Laboratory 1993.)

Candidates for Combined Kidney-Pancreas Transplants

The decision to perform a combined kidney-pancreas transplant in diabetic patients with end-

stage renal disease is based on three factors:

- The best kidney for the patient.
- The ability of the patient to undergo the additional technical complications associated with pancreas transplantation.
- The patient's desire for a pancreas transplant.

As a rule, diabetic patients with end-stage renal disease who are candidates for kidney transplantation are also candidates for pancreas transplantation if they have been evaluated successfully for kidney transplantation (Table 1). Patients must be younger than 50-years-old, ambulatory without significant amputation, without severe diabetic neurologic or atherosclerotic complications, have had a psychiatric evaluation to determine level of patient compliance as well as any history of narcotic abuse, and must have undergone the additional tests required for pancreas transplant (ie, cardiac catheterization, measurement for insulin antibodies and islet cell antibodies, noninvasive ultrasound evaluation of the lower extremities).

At our institution, the patient is evaluated by a nephrologist; by one of the transplant surgeons; and then by the transplant coordinators, social workers, psychiatrists, and financial counselors. Laboratory tests and physical examinations follow. The patient is then evaluated by the End-Stage Renal Disease Committee. Only after passing each of these preliminary steps is the name of the patient placed on the waiting list of the United Network for Organ Sharing for a kidney and pancreas transplantation.

Studies have shown that kidney survival is longer and has fewer episodes of rejection when it originates from a living-related donor.[1] If patients have a living-related donor, they are encouraged to undergo living-related kidney transplantation, then 1 year later is followed with a cadaveric pancreas transplantation if the patient still desires a pancreas transplantation at that time. Transplant patients older than 50 years have a significantly higher incidence of morbidity, including life-threatening complications and death following pancreas transplantation alone or with a kidney.[2]

Transplantation of the pancreas (both kidney-pancreas or pancreas alone) is a complex process. In addition to the obvious attention to detail that is required for the procedure, a close working relationship also must be maintained with the patient. This is the role of the transplant coordinator. The coordinator is responsible for the evaluation work-up of the candidates, contact with the patients before the transplantation, and contact with the families of the patients during transplantations. In addition, the coordinator not only maintains this contact at transplantation but throughout the life of the patient. These coordinators handle all changes with medication and maintain the official records of the post-transplant laboratory values. They serve as liaison between the Transplant Center, the transplant surgeons, and the referring physicians.

Table 1. Workup of Patential Diabetic Recipients Priar ta Kidney Transplantatian

1. Hematalagic evaluatian
   a. Hemaglabin
   b. Leukacyte differential and platelet caunts
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2. Renal evaluatian
   a. Flat plate af abdamen (kidney size)
   b. Creatinine clearance
   c. 24-haur pratein excretian
   d. Electralyte status including calcium ta assess far hyperparathyraidism
   e. Urinalysis and urine culture
3. Cardiac evaluatian
   a. Chest x-ray (heart size)
   b. ECG
   c. Serial blaad pressures
   d. Dipyridamale-thallium stress test
   e. Caranary arteriagram and treatment af significant lesians pretransplant (angiaplasty ar bypass)
4. Uralagic evaluatian, including vaiding cystagram
5. Upper gastraintestinal x-ray studies ar endascapy if histary af ulcer disease
6. Tissue typing
   a. ABO
   b. Human leukacyte antigen tissue typing
   c. Serial antileukacyte antibady determinatians
7. Infectiaus warkup
   a. Chest x-ray
   b. Skin tests
   c. Culture af urine, blaad, and thraat
8. Evaluatian af caexisting diabetic camplicatians
   a. Ophthalmalagic examinatian
   b. Neuralagic examinatian
9. Financial-sacial rehabilitatian evaluatian

With permissian fram Barker CF, Sutherland DER, Belzer FO. *Management af the diabetic transplant patient: renal and pancreatic transplantatian.* Madisan, WI: American Saciety af Transplant Surgeans, 1988.

The Donor Operation and the Donor

One of the most important aspects of the combined kidney-pancreas transplantation is the donor operation. The evaluation of cadaveric donors is very important since it can significantly influence graft survival and the rate of complica-

tions. In Kentucky, we require donors for pancreas transplantation to be less than 45-years-old, have no family history of diabetes, and have no evidence of pancreatic trauma or pancreatitis. Additionally, the donors must be of normal body habitus (obese patients are excluded). Donors who weigh less than 20 kg are not accepted secondary to technical complications with small vessels.

The donor operation requires the same skill and preparation as the actual transplantation. Only surgeons who are qualified to perform pancreas transplantations should remove the donor pancreas. The operation is similar to a multiorgan donor procedure and involves complete mobilization of the pancreas from all its retroperitoneal and mesenteric attachments. The spleen is used as a maneuvering device to help dissect the tail of the pancreas over to the level of the aorta. The duodenum is irrigated with a Betadine solution before it is stapled and divided just distal to the pylorus and again at the ligament of Treitz. The superior mesenteric artery distribution of the small bowel mesentery is stapled and subsequently undersewn to prevent bleeding. The superior mesenteric artery itself is removed from the aorta with a small patch of aorta still attached, and the splenic artery is divided at its entry into the celiac access. The portal vein is divided at the entry of the coronary vein. If the liver is not being used for transplant, then the portal vein is divided at the edge of the liver parenchyma. Once the pancreas and attached duodenum have been flushed with University of Wisconsin solution during the organ procurement procedure and chilled with iced saline, they are removed and placed in a container with University of Wisconsin solution. The pancreas is stored at 4°C in University of Wisconsin solution and can remain viable with no impairment of function or increase in pancreatitis for up to 24 hours.

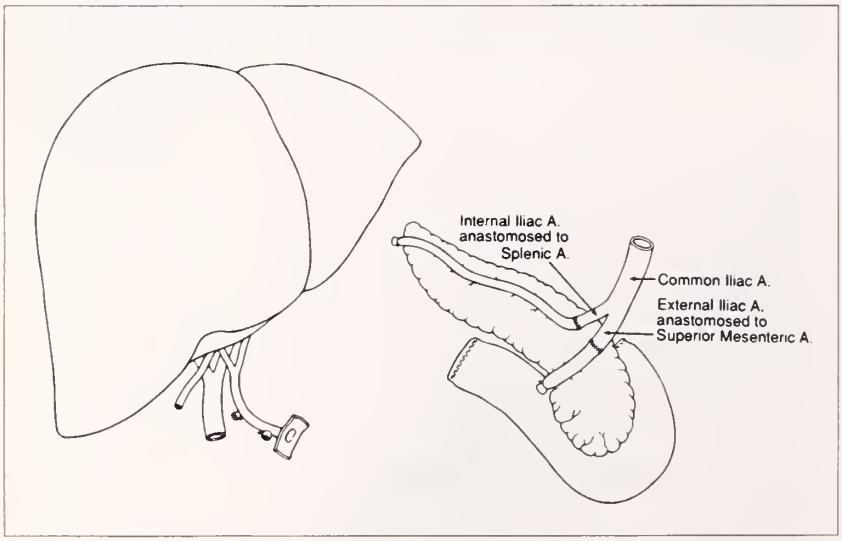


Fig 2 — A pancreas graft prepared for implantation. (Reprinted with permission from Sollinger HW, Knechtle SJ. The current status of combined kidney-pancreas transplantation. In: Sabiston DC Jr, ed. Textbook of Surgery. Philadelphia: WB Saunders, 1991.)

Surgical Technique

The technique for performing a combined kidney-pancreas transplant differs from that of a standard kidney transplant in many ways. The incision is through the midline, extending from approximately 3 inches below the tip of the xiphoid process to the pubis. When the abdomen is entered, the internal and external iliac arteries and veins on both sides are dissected free to allow for the later anastomosis of the pancreas with the right common iliac artery and vein and the kidney with the left external iliac artery and vein. An important stage of a pancreas transplantation involves the "back table work" to prepare the new pancreas for insertion. This requires approximately 1½ hours of work and involves the removal of the spleen from the tail of the pancreas, ligation of all small bleeding vessels, ligation of the superior mesenteric artery distribution in the small bowel mesentery, shortening of the distal duodenum, oversewing of the proximal duodenal stump, and finally the Y-graft anastomosis for reconstruction of the arterial system (Fig 2).

Once the "back table work" on the donor pancreas is completed, it is anastomosed to the right common iliac artery and vein as shown in Fig 3. The kidney is anastomosed on the left side to the external iliac artery and vein. After completion of the vascular anastomoses of both the kidney and the pancreas and ligation of bleeding vessels, the bladder is opened and the duodenocystostomy is performed on the dome of the bladder. A 25-mm end-to-end anastomotic device is placed through the open distal end of the duodenum and into the wall of the bladder. This anastomosis is oversewn from the inside using PDS sutures for hemostasis and to pull the mucosa of the bladder over the staple line to prevent stone formation from foreign bodies in the bladder. The ureter is inserted into the bladder in a standard

Leadbetter-Politano anastomosis. The bladder is closed in three layers, and the urinary bladder catheter is maintained for 10 to 14 days after transplantation.

Postoperative Management

The postoperative management of the combined kidney-pancreas transplant patient is similar to that of the kidney transplant patient but with the following additional steps. The combined transplant patient is automatically sent to the Intensive Care Unit for cardiac monitoring. An insulin drip is used to maintain the glucose level between 70 mg/dl and 150 mg/dl, and antibiotic administration is continued until duodenal stump cultures are negative. Antibiotics include ciprofloxacin, vancomycin, and fluconazole. Patients require nasogastric decompression, and metoclopramide or cisapride for gastrointestinal motility is often needed in the postoperative period. Immunosuppression is similar to that for a kidney transplant, (OKT-3 monoclonal antibody or antithymocyte globulin for 10 days, with azathioprine and prednisone in the immediate postoperative period). Cyclosporine is started on postoperative day 8, with a 2-day overlap with the antilymphocyte therapy. Urine collections are made daily (every 24 hours) for amylase content to assess pancreatic function.

Rejection episodes, while more common in the combined kidney-pancreas transplant group (80% in the first year), do not alter the graft survival for the kidney when compared with those patients who have had a kidney transplant alone.[3] In 90% of the cases, a rejection episode occurs in both the kidney and the pancreas simultaneously. However, in 10% of the cases, only the pancreas is involved. In this difficult situation, pancreatic biopsy by cystoscopic guidance into the duodenum may be the only option. After the first year, rejection episodes in both the kidney and the pancreas, when they do occur, occur simultaneously more than 95% of the time.

Results

An examination of the results of the combined kidney-pancreas transplantation effort in the United States reveals that this is a highly successful procedure. A recent study presented by Robert Stratta, MD, to the American Society of Transplant Physicians in Chicago, showed that the 2-year patient survival was 96%, kidney graft survival was 90%, and pancreas graft survival was 89%. These results have been confirmed at other transplant centers in the United States. The International Pancreas Transplant Registry shows equal survival for kidney transplantation alone or with a pancreas. In transplants performed at our center since 1990, 67% of the pancreas grafts were still functional at follow-up (mean, 22 months). There has been 100% patient and graft survival in the 9 combined kidney-pancreas transplants that were performed within the past 12 months. All patients and grafts were fully functioning and insulin-dependent. As better methods for screening rejection become available, and the effects of more stringent donor and recipient criteria are manifested, we expect our results to continue to approach the 90% mark for both kidney and pan-

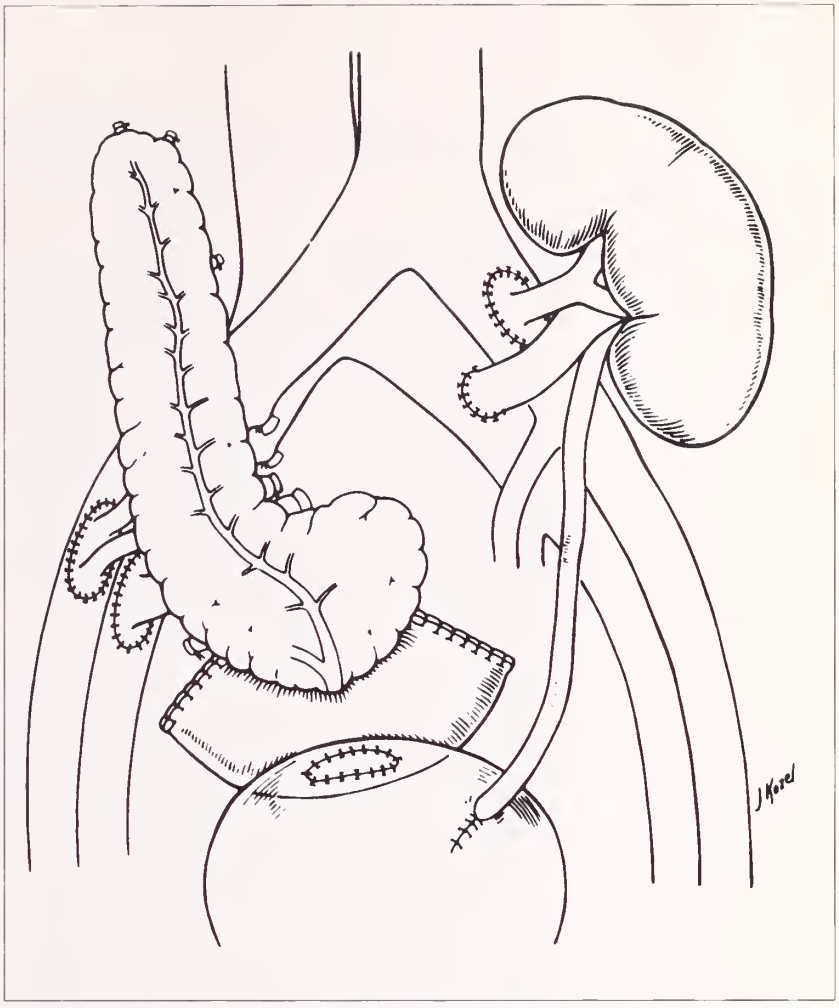


Fig 3 — The position and anastomoses of the kidney and pancreas after implantation. (Reprinted with permission from Sollinger HW, Knechtle SJ. The current status of combined kidney-pancreas transplantation. In: Sabiston DC Jr, ed. Textbook of Surgery. Philadelphia: WB Saunders, 1991.)

creas graft survival at 3 years, with no further graft loss at 5 years.

Risks and Benefits

Combined kidney-pancreas transplantation is the procedure of choice for selected uremic, diabetic patients. The success of this procedure is on a par with kidney transplant alone, but there are additional risks that are significant. Many of the risks seen in the initial 30 days after surgery are related to surgical complications, including an increased incidence of abdominal abscess, infection, and small bowel obstruction. The most significant complication is reoperation, which occurs in approximately 15% to 20% of these patients.[4] In comparison with kidney transplantation alone, there is an increased incidence of urinary leaks, the initial hospital stay is often longer by an average of 1 additional week, and there is an average 1 additional hospital admission per year to treat metabolic problems that may occur within the first year. Also, wound and bladder infection rates are higher in the combined kidney-pancreas group *versus* the kidney-alone group. Despite all of these complications, the patient and graft survival rate for a combined kidney-pancreas transplant is the same as for a kidney transplant alone.[5] This reflects well on our ability to diagnose and/or prevent complications in the majority of patients.

The benefits of pancreas transplantation have been recognized over the last few years. They include metabolic changes, such as a normalization of the glycosylated hemoglobin A1C, normal intravenous glucose tolerance tests, and 24-hour glucose profiles. In addition, there are recent reports that lipid levels in combined kidney-pancreas transplants patients are significantly better than those in well-matched diabetic kidney transplants alone. Also, cholesterol levels in combined kidney-pancreas transplants are significantly lower than in diabetic living-related kidney transplants. Autonomic neuropathy and peripheral neuropathy are also improved in patients after combined kidney-pancreas transplants *versus* patients who received a kidney transplant alone.

Tests for gastric emptying, motility studies, the R-wave to R-wave interval on EKG during a Valsalva maneuver,[6] and nerve conduction velocity have also been measured prior to transplant and at 3, 6, and 12 months after transplant. Recent changes in the microangiopathy, as measured by the transcutaneous oxygen levels, have been reported. Patients with a combined kidney-pancreas transplant have been shown to have significant improvement in their transcutaneous oxygen levels when compared with patients with a kidney transplant alone. There is currently no data, however, as to whether this will result in significant improvement in limb salvage or reduce the occurrence of diabetic ulcers in patients with combined kidney-pancreas transplantation.[7]

An area that is very controversial and certainly of great concern to the diabetic patient is that of diabetic retinopathy. Most studies do not show that retinopathy improves after a combined kidney-pancreas transplant, and indeed, it seems that the progression of retinopathy after transplant is the same for kidney transplants with or without a pancreas. In some studies, however, it appears that the diabetic retinopathy actually regresses in more patients than it progresses. These studies need to be confirmed, but these results are certainly encouraging.[8] All of the studies comparing quality of life parameters and psychological welfare of a diabetic patient who undergoes a combined kidney-pancreas *versus* a kidney transplant alone have indicated a higher level of psychological well being, satisfaction, and quality of life after the combined transplant.[9]

The majority of pancreas transplants performed at the University of Louisville are combined with kidney transplants. However, we also perform pancreas transplantation alone or after kidney transplants. The graft survival for pancreas transplants alone or pancreas transplant after kidney transplant is not as good as that for the combined group. Indeed, for the non-uremic diabetic patient, it is questionable if the risks of immunosuppression exceed the risks of the development of secondary complications of diabetes. The effect of pancreas transplantation on the course of established complications is unknown. However, in patients with extreme lability of metabolic control and poor quality of life, pancreas transplantation is justified. Life expectancy for this small population is very short due to hypoglycemia and metabolic acidosis, and indirectly from automobile accidents due to the increased risk of losing consciousness while driving. Some of the concerns that we have about the pancreas-alone transplant include the side effects of immune suppression, notably that of cyclosporine, which is nephrotoxic. In many patients with diabetes, nephropathy has already started, and, while they are not candidates for renal transplantation (ie, they do not have renal failure), the addition of

cyclosporine for a pancreas-only transplant can often decrease an already low creatinine clearance. Kidney biopsies in patients who have had only a pancreas transplant show improvement of the diabetic lesions in the native kidney, but they do develop interstitial fibrosis, which is presumed to be secondary to cyclosporine. To consider a patient as a candidate for pancreas transplant alone, the following questions should be answered. Will the management of the immunosuppressive drugs be more or less difficult than the management of the insulin? Will the benefits of insulin independence offset the infectious side effects of the cyclosporine and antilymphocyte therapy? Will a pancreas transplant improve survival?

The pancreas transplantation team at the University of Louisville has performed transplants in a total of 35 patients since March 1987. The oldest recipient with functioning grafts had a combined kidney-pancreas transplant performed in April 1987. Since 1990, 21 pancreas transplants have been performed, with a 2-year graft survival rate of 67%. All of the transplants that have been performed in the last 1½ years are still functioning. We expect that our graft survival rate will continue to improve as immunosuppression and detection of rejection improve.

Conclusions

Pancreas transplantation in combination with kidney transplantation is an option whose time has come and is a successful procedure for patients with end-stage renal disease. The risks associated with this procedure are concentrated in the first 3 months of the postoperative period. These risks are justified because the metabolic complications of Type I diabetes are corrected, and the function and survival of the kidney transplant is not adversely affected by the addition of the pancreas graft. The quality of life is significantly better in those patients who have had combined kidney-pancreas transplant than in those diabetics who have had only a kidney transplant. For those patients who are candidates for kidney and pancreas transplantation, it should be considered the treatment of choice.

The beneficial aspects of pancreas transplantation alone are more difficult to evaluate. The risks are higher due to the addition of immune suppression in patients who would otherwise not be immune suppressed. The benefits are concentrated in the area of life-style more than treatment of complications. Even so, for those patients with labile diabetes and uncontrolled hyper/hypoglycemic swings despite optimal insulin therapy, the addition of pancreas transplant can offer independence from the medical complications and constraints imposed by diabetes. These patients can then reenter the workforce and regain control of their lives.

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Medical Gender Politics

"Have more changes occurred during the 1990s in medicine due to legislative health care reforms or from medical gender politics?"

Health Care Reform may not be the issue that will impact most on the future practice of medicine.

The growing numbers of women in medicine are bringing changes just as revolutionary as Health Care Reform.

Shared and part-time residencies and practices; taking time to rear families and plan futures; medicine's melting pot has become a mosaic of integrating medical education and practice with family values and obligations.

Women in medicine have necessitated a mobile, more flexible profession. Juggling foleys with pacifiers — struggling to palliate and fulfill the egos and ambitions of two-career families — women are exhibiting highly creative solutions to these problems. Studies show as some women in medicine seek and secure jobs with scheduled hours and fixed salaries, such arrangements have become more common for both genders.

Gender politics is changing medicine in a manner much more dramatically than our population as a whole. The rallying cry today is not as much equality of opportunity, pay, or specialty choice as it was when I was a resident. The rallying cry amongst today's women in medicine is that medicine has to be changed to allow lifestyles that include rearing families and pursuing interests outside of medicine for both men and women.

Mark my words and circle the year 2000 on your calendars. Make a point of reflecting on this question at that time. . . . Have more changes occurred during the 1990s in medicine due to legislative health care reforms or from medical gender politics? Both have the potential to make the practice of medicine far different than it was when we first entered this profession.

My computerized magnetic resonance crystal ball predicts that gender politics over the long haul will make medicine a healthier profession for men and women alike, with the families of physicians being the real winners.

Jannice O. Aaron, MD

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Joyce Clark

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We are all concerned about health care in this country — the direction it is going, the impact it will have on your patients and families, the type of practice you will have and the paperwork involved. It is past time for us to "unite with one voice" for the future of medicine.

Every physician and physician spouse needs to unite to have an impact on pending legislation — legislation that will ultimately affect each of us and the lives of your patients. The one positive thing that we can do is to join our respective organizations. ***JOIN TODAY*** Join KMA and KMAA. Join KEMPAC. Join the national organization.

PHYSICIANS!!! If you wish to purchase a **gift certificate** for your spouse, you may do so by simply filling out the form below and returning it with a check for $40.00 made payable to KMAA (Kentucky Medical Association Alliance).

Thank you for taking a part in "the future of medicine" by purchasing this gift certificate.

Joyce Clark

KMA Alliance President

Mail this form and check to KMAA Headquarters, Attn Jean Wayne, 301 N Hurstbourne Pkwy, Suite 200, Louisville, KY 40222-8512.

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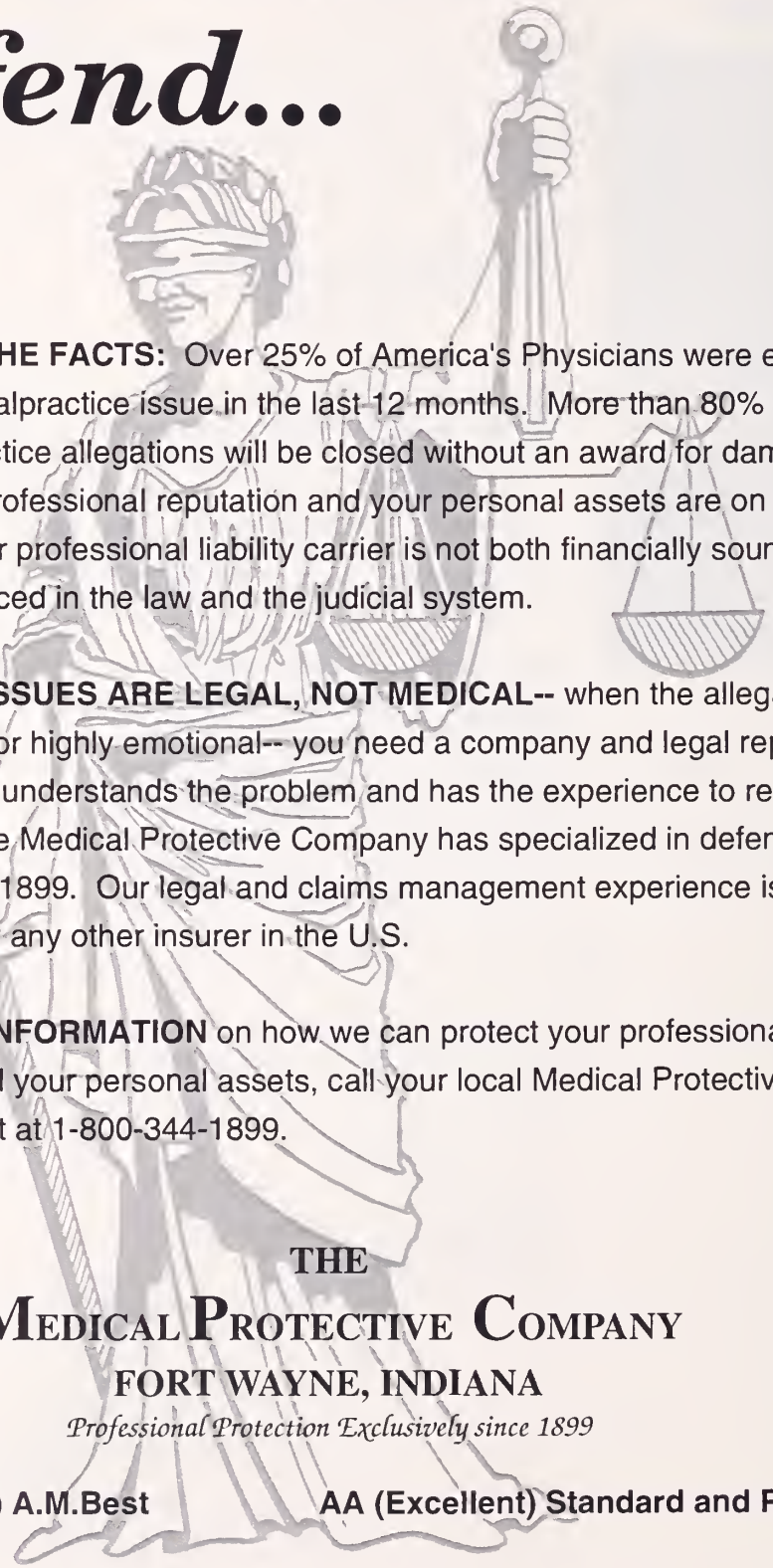
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A Tribute

To the Editor: Alvin C. Poweleit, MD, a respected Senior Physician from Kenton County, Kentucky, has attended several of our CATO Society meetings and has numerous friends in the JCMS. Honored heroes of WWII are becoming scarce. That we may acquaint our younger members with a fine example of the "vanishing species," we present the following, which was read into the *Congressional Record* on March 11, 1994, by US Senator Mitch McConnell and is republished here by permission of the Senator.

Eugene H. Conner, MD
Chairman of Sr Physicians' Committee, JCMS

Tribute to Dr Alvin C. Poweleit Honoring a Kentuckian's Heroism and Professional Life

Mr President, I rise today to pay tribute to a distinguished Kentucky gentleman and a personal friend. Dr Alvin C. Poweleit of Newport, Kentucky has lived a full life, distinguished by its honor, heroism and dedication to helping those in need.

Dr Poweleit's outstanding service began during World War II when as a member of Kentucky's Fighting 192nd Light G.H.Q. Tank Battalion he served as the battalion surgeon. As a member of one of the most valiant fighting forces in our nation's history, Dr Poweleit experienced the horrors of war firsthand. After bravely defending the battalion's position in Japan [sic] the 192nd was overrun by the vastly superior force and numbers of the enemy.

Mr President, Dr Poweleit survived the Bataan death march which followed as well as an extended time in a Japanese prisoner of war camp. It was while suffering in this camp, where many prisoners lost 40% to 60% of their total body weight, that Dr Poweleit made a commitment to himself that he would spend his life caring for others. This was not a commitment made without conviction.

He returned to northern Kentucky a Lt Colonel Medical Corp and a highly decorated war hero. Dr Poweleit received the Silver Star, Legion of Merit, Purple Heart, Philippine Defense Medal and Presidential Unit Citation Medal as a result of his distinguished service in defense of America. He was the first medical officer to be decorated in World War II. He received the Legion of Merit award for heroism he displayed when he dove underneath a partially submerged burning tank to rescue two trapped soldiers.

Mr President, Dr Poweleit did not rest on his laurels. Remembering the promise he had made half a world away and under horrific circumstances, he dedicated his life to serving his community and helping others. As long as he has been in practice he has never refused treatment to a patient in need. Always available, Dr Poweleit gladly dispensed treatment and compassion whenever it was needed. As he is fond of saying "there are talkers and there are doers," and there is no doubt which category he falls under. Being a doctor is both his vocation as well as avocation.

Mr President, Dr Poweleit is not in practice anymore but he is still remembered fondly by all who know him. As the author of many books, both about his war experiences and the northern Kentucky medical community, his legacy will live on for many years to come. But to the generations of Kentucky families whose lives he enriched and cared for he will never be replaced.

Mr President I ask my colleagues to join me in honoring this wonderful Kentucky gentleman and my friend, Dr Alvin C. Poweleit.

US Senator Mitch McConnell

Medicare Fraud Alert

To the Editor: There is an active scheme of fraud going on in Kentucky at this time.

Primary care physicians refer patients to a consultant who, having made an initial office consultation, sets up a follow-up visit. On the occasion of the follow-up visit of the patient to the consultant, the consultant sends another report to the referring family practitioner. Accompanying this report is a self-addressed postcard with a checkoff on the back which the original referring physician is asked to check that he has asked the consultant to see this patient again.

Please see page 33, 1994 CPT book, second paragraph of office or other outpatient consultations on new or established patients. Quote: "Follow-up visits in the consultant's office or other outpatient facility that are initiated by the physician consultant are reported using office visit codes for established patients. (CPT 99211 through 99215) If an additional request for an opinion or advice regarding the same or a new problem is received from the attending physician and documented in the medical records, the office consultation codes may be used again."

In Area One for Kentucky, the established patient office visits 99211 through 99215 pay to a participating physician $11.96 to $76.15. Office

follow-up consultations on established patients, same area, same situation, CPT code 99241-99245 pay from $41.39 to $151.92.

If the referring physician checks this postcard off and returns it, it serves as documentation that he asked for this consultation and that it was not an office visit.

Should this happen, both the consultant and the referring physician are engaging in fraudulent practices. They are subject to all the penalties this office can bring to bear.

I am appalled at and very disappointed in my colleagues who are participating in this fraudulent activity.

We will be referring identified perpetrators to the Fraud Unit and Office of Inspector General (OIG) for appropriate action, commensurate with the offense.

J. B. Holloway, MD

Too Many Tests and Procedures?

TO THE EDITOR: Many of us use a great many laboratory, X-ray, and other procedures as a screening device. This is an accepted way to practice medicine and one reason why we do so well at early diagnosis and treatment. Unfortunately, with the very recent exception of pap smears and mammography, Medicare does not pay for screening or "routine" tests. Most patients and many physicians do not understand this.

This lack of understanding leads to many problems between physicians and the Health Care Financing Administration.

This is incontrovertible evidence that there is overutilization of laboratory, X-ray, and other procedures in the workup of patients to solve diagnostic problems. Why is this?

The cynical health care experts point to conflict of interest. We own the machines and profit by every test done. True in some instances, but not nearly to the extent proclaimed.

The physicians say it is defensive medicine. They must do all this to avoid litigation. Again, true but not to the extent we insist.

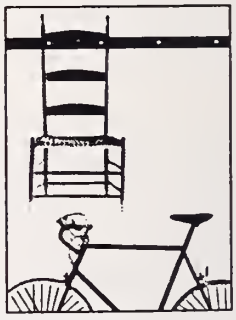
In my judgment, there is a third and almost inherent reason. We are trained that way. In our functions in medical school and residency years, all must be done. First, to have us learn the use and efficacy of all our technology. Secondly, as residents coming up the ladder, we dare not skip something for fear that in our rounds we will look the fool. No one ever mentions finite resources, budget caps, reasonable conservation of our patient's pocketbook on this government's coffers.

If we gave thought to the three factors listed above, if we used prudence and wisdom in our ordering of all procedures whether a simple urine or a CAT scan, the saving would amount to Billions a year. We would not be faced with the dilemmas being forced upon us today.

A good history, physical exam, application of judgment, will get us where we ought to go with a minimum of procedures leading to a diagnosis.

A 20-year-old seen in the ER, with RLQ pain, fever spasm, and tenderness in the RLQ needs a urine, CBC, and if the hospital requires it, a chest film. He does not need abdominal X-rays, ultrasound, and CAT scan before his appendix is removed.

J. B. Holloway, MD
Medical Director
Medicare Contracts



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TO HELP OTHERS WE MUST HELP EACH OTHER

As physicians, we are responsible for the health and well-being of those around us. When a physician develops problems that impair his or her ability to carry out professional responsibilities, it's up to us to help.

The goal of the impaired physicians program of the Kentucky Medical Association is to assist physicians and their families who are demonstrating problems associated with the inappropriate use of alcohol and/or drugs, emotional and mental disability, or the aging process.

The committee supports a policy of early identification, by self, colleagues, or others, and active intervention to bring prompt assistance to the physician while ensuring the welfare of his or her patients. The policy is designed to ensure referral to acceptable treatment resources with the aim of full rehabilitation.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

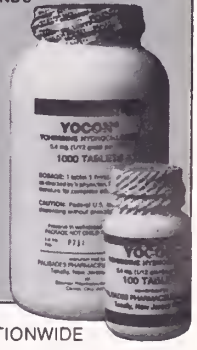
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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PEOPLE

Beverly M. Gaines, MD, a Louisville pediatrician, has been appointed to the state's first Health Policy Board.

On July 15 Governor Brereton C. Jones announced four appointments to the Board, as established by the Administration's landmark Health Care Reform Act, signed into law by the Governor April 15.

Dr Gaines serves as co-chair of the Quality Committee for the Governor's Task Force on Health Care Access and Affordability.

Robert R. Goodin, MD, KMA President-Elect, was recently named to the American Medical Association Federation Study Consortium. The Consortium study has been initiated by AMA in response to the changing health environment, the greater diversity of the physician population, the increased pressure on resources, and the need for unity of purpose and action among organized medicine.

Edward L. W. Scofield, MD, Immediate Past President, Jefferson County Medical Society, and **Judy Linger, MD,** President, KMA Resident Physicians Section and a member of the Governing Council of the AMA Resident Physicians Section, were also selected to represent Kentucky on the Consortium.

Paul F. Maddox, MD, Campton, received the first "Good Samaritan" Award at the Good Samaritan Foundation, Inc annual dinner held recently at Marriott's Griffin Gate, Lexington.

The "Good Samaritan" award received by Dr Maddox is designed to recognize a Kentuckian who has made significant contributions in the area of health and/or health care education over an extended period of time. "The award is intended to be for extraordinary personal contributions especially where it has made a significant impact in providing or improving the access, delivery or general health of low income people in underserved areas," said Foundation President, Arch G. Mainous, Jr.

"The selection of Dr Maddox for the first Good Samaritan Award is an excellent choice. He is known to have spent a lifetime in providing needed health care to the people in his community without regard to their ability to pay," said Rev Albert W. Sweazy, chairman of the awards committee.

The Good Samaritan Foundation, Inc is a nonprofit educational and charitable organization. Candidates names for next year's Good Samaritan Award should be sent to the foundation by March 31, 1995, President Mainous said. The award may be given each year at the dinner.

Larry J. Wilson, MD, FACR, a Louisville diagnostic radiologist, has been installed as President of the Kentucky Chapter of the American College of Radiology. Dr Wilson is Medical Director of Radiology at Saints Mary & Elizabeth Hospital. For the past 4 years, he has served as KMA 5th District Alternate Trustee. Dr Wilson recently completed a 4-year term as Founding Director and Secretary of The Physicians Incorporated, a 1,300 physician member Independent Practice Organization.



Dr Rivard Recognized for Membership Recruitment

Thanks to KMA member, Arthur K. Rivard, MD, Danville, the Association and the Boyle County Medical Society have gained several new members and Dr Rivard will get a 20% discount for 1995 KMA dues for his efforts. Participating in the KMA "Member-Get-A-Member" Campaign initiated at the 1993 KMA Annual Meeting, Dr Rivard made personal contacts to physicians in his area which, according to KMA Membership Chair Harold Haller, MD, "is the most effective way to convince nonmembers to participate."

Dr Rivard, an ophthalmologist who graduated from and did his residency at the University of Kentucky Medical Center, serves as KMA Delegate from the Boyle County Medical Society.

To find out more about the "Member-Get-A-Member" Program, contact the KMA Membership Department at 502/426-6200.

Hiram Polk, Jr, MD, Department of Surgery, University of Louisville, was elected president of the Southeastern Surgical Congress at the group's 62nd annual meeting in Florida. He also was named chairman of the board of Goodwill Industries of Kentucky.

William B. Monnig, MD, Edgewood, was elected as a board member at large to the Governing Council of the Hospital Medical Staff Section of the American Medical Association at its recent Annual Meeting in Chicago. Dr Monnig, Immediate Past President of the KMA, has long been active in HMSS efforts at both the state and national levels and was one of the founding members and Chair of the KMA HMSS. The HMSS Governing Council is a seven-person body that executes policy set by the Representative Assembly body. The Council consists of three officers, a Delegate and Alternate Delegate to the AMA, and two members-at-large, each of whom serve 2-year terms.

Henry D. Garretson, MD, has been appointed chair of the newly designated Department of Neurological Surgery at U of L School of Medicine. His professional honors include election as chair of the American Board of Neurological Surgeons, Society of University Neurosurgeons, and the Southern Neurological Society.

David H. Adamkin, MD, U of L professor of Pediatrics, was recently named director of the Division of Neonatal Medicine and director of Nurseries for Kosair Children's Hospital. He chairs the Neonatal Intensive Care Unit Multidiscipline Committee, NICU Advisory Committee, and Newborn Advising Committee.

T. Jeffery Wieman, MD, professor with U of L Department of Surgery, was chosen by a medical staff selection committee for the position of medical director of the Alliant Cancer Treatment Center for Adult Services. He will devote half his time to strategic planning for Alliant.

UPDATES

U of L Researchers Study Possible Link Between Germ and Coronary Artery Disease

University of Louisville and Johns Hopkins University researchers have announced results of a study which supports the possibility of a link between a newly-discovered bacterium and atherosclerosis.

The researchers have proven that *Chlamydia Pneumoniae,* a germ discovered about 2 years ago, can grow and reproduce in the cells that line the walls of human arteries. The research builds on European statistical data that linked evidence of germ infection in cell walls with the occurrence of heart attacks.

"We know the buildup of fat and debris (called plaque) in arteries is a leading cause of heart attack," said **Julio Ramirez, MD,** chief of the Division of Infectious Diseases at the U of L School of Medicine. "We wanted to know if some initial infection could damage the arterial walls and encourage the buildup of plaque."

Scientists first had to prove that the pneumonia germ could grow in smooth muscle cells, Dr Ramirez said. They announced at the 93rd General Meeting of the American Society for Microbiology that they have successfully done so in a laboratory setting.

In plastic dishes filled with growth medium, they grew smooth muscle cells, similar to the kind found in coronary artery walls, then added the bacteria and let it incubate for 2 days. Using an antibody that binds only to the bacteria as their microscopic marker, scientists confirmed the germ's presence.

"It's just the first step," said Dr Ramirez. "Ideally, if we found this bacterium is the cause of heart disease, we might be able to develop a vaccine to prevent atherosclerosis."

The U of L research was funded in part with grants from Alliant Health Systems, Jewish Hospital, and the American Heart Association of Kentucky.

Coral as a Bone Rebuilder

Coral may make a better bone replacement than bone itself, says a University of Louisville orthopedic surgeon. **Dr David Seligson** is using coral to repair some bone injuries. The crusty sea creature's makeup and density are similar to bone's, and its interconnecting pores make a good scaffolding through which replacement tissue can grow. In 5 to 10 years, the body rebuilds bone as it breaks the coral down and absorbs it.

According to the University, the surgery costs less than bone grafting, lessens the risk of complications, and may shorten the patient's hospital stay.

Kentucky Medical Insurance Elects New Directors

Kentucky Medical Insurance Company elected three Class A and three Class B directors at its annual shareholders' meeting, held July 28 in Louisville.

The new Class A directors, which serve a 1-year term, are **Ronald N. Collier, MD,** a pediatrician; Ronald G. Geary, CPA, JD, President and CEO of Res-Care Inc; and **William B. Monnig, MD,** a urologist.

Drs Collier and Monnig are

returning board members. This is Mr Geary's first year on Kentucky Medical's board.

Elected to represent Class B shares for a 3-year term were **Donald C. Barton, MD, Richard F. Hench, MD, and James R. Wilkinson, MD.** All three are returning Class B board members. The Class B shares are held exclusively by the Kentucky Medical Association.

Later in the day, at a regularly scheduled meeting, Dr Barton retired from the board and **Danny M. Clark, MD,** was elected to fill Dr Barton's unexpired term. Dr Clark is also a returning board member.

The company also announced that its A. M. Best rating of A-(Excellent) has been reconfirmed for 1994.

Division of Seven Counties Services, Inc Chosen for National Mental Health Award

The Centers for Specialized Child & Family Service, a division of Seven Counties Services, Inc in Louisville, achieved national recognition when it was awarded the National Community Mental Healthcare Council's (NCMHC) 1994 Special Program Award for its programs serving emotionally disturbed children and their families.

The award recognizes outstanding, innovative programs serving children with emotional disturbances and adults with severe mental illnesses. It is one of the NCMHC's Awards of Excellence given each year honoring an organization's achievements in areas of advocacy, organizational effectiveness, innovative funding for service delivery, and special programming.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Boyd

Robert Di Giulio, MD — IM
1230 Charleston Ave, Huntington, WV 25701
1990, American U of Caribbean

Barnett S. Salzman, MD — P
123 Buena Vista Dr, Ashland 41101
1965, SUNY, Buffalo

Boyle

Kursheed A. Siddigui, MD — AN
410 Pleasantwood Dr, Danville 40422
1988, Eastern VA Med School

Bourbon

Daniel J. Cardona, MD — P
777 Stone Road, Paris 40361
1987, U of Michigan

Crittenden

Emelita A. Ayos, MD — R
Crittenden Co Hosp, Marion 42064
1969, Far Eastern U

Daviess

Ian H. Freirich, MD — P
811 E Parrish Ave, Owensboro 42303
1982, Albany Med Col

John S. Mulligan, Jr, MD — R
P O Box 2230, Owensboro 42302
1985, U of Kentucky

John C. Powell, MD — TS
815 E Parrish Ave, Owensboro 42303
1986, Washington U, St Louis

Fayette

Manoochehr Mazloomdoost, MD — AN
1800 Nicholasville Rd #101, Lexington 40503
1964, Shiraz U, Iran

Mohammed Mohiuddin, MD — R
UKMC — Radiation Med, Lexington 40536
1968, Osmania Med Col, India

Allen Sloan, MD — AN
280 Stone Rd, Lexington 40503
1987, Med Col of Georgia

Floyd

Mark C. Moore, MD — AN
P O Box 45, Auxier 41602
1987, U of South Carolina

Graves

Sven H. Martenson, MD — FP
1029 Medical Center Cir, Mayfield 42066
1982, American U of Caribbean

Hardin

Paul A. Garner, MD — AN
50 Woodsbend Dr, Elizabethtown 42701
1988, Indiana U

James P. Murphy, MD — AN
707 Lansdowne Ct, Elizabethtown 42701
1985, U of Louisville

Henderson

Michael J. Maloney, MD — AN
1305 N Elm St, Henderson 42420
1985, UTESA

Jefferson

Timothy J. Doyle, MD — N
14017 Harbour Pl, Prospect 40059
1986, St. George's U

Lounette H. Humphrey, MD — P
234 E Gray #470, Louisville 40202
1989, U of Louisville

Christopher J. Kirk, MD — IM
6500 Preston Hwy, Louisville 40219
1983, U of Nevada

Mary S. Lewis, MD — IM
224 E Broadway #700, Louisville 40202
1984, U of Louisville

Michael E. Lowrey, MD — IM
1919 State St #100, New Albany IN 47150
1961, U of Louisville

Stephen C. Sorenson, MD — EM
900 Glenbrook Rd, Louisville 40223
1987, SUNY, Buffalo

Emilio D. Soria, MD — N
7606 Deer Meadow Dr, Louisville 40241
1971, U of Salamanca, Spain

Johnson

Timothy R. Wagner, MD — ORS
229 S Mayo Tr, Paintsville 41240
1975, Temple U

Lewis

Martha L. Guzman, MD — FP
P O Box 550, Vanceburg 41179
1985, U Francisco Marroquin, Guatemala

Laurel

Dave M. Purcell, MD — IM
317 Spring St #7, London 40741
1987, St George's U

Madison

Thomas J. Vaughan, MD — R
213 Short St, Berea 40403
1963, Med Col of VA

Perry

Gilroy L. Daley, MD — R
200 Medical Ctr Dr, Hazard 41701
1967, U of Louisville

Rowan

Robert E. Young, MD — EM
P O Box 1050, Morehead 40351
1974, Albert Einstein Col of Med

Warren

Maria Garber, MD — OPH
909 Wrenwood Dr, Bowling Green 42103
1967, U of Latvia

Keith A. Hewitt, MD — OBG
1300 Andrea #207, Bowling Green 42101
1986, U of Louisville

In-Training

Fayette

David B. Andreas, MD — IM
Christopher Warimont, MD — PD
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DEATHS

David Shapiro, MD
Palm Beach Gardens, FL
1912–1994

David Shapiro, MD, a retired radiologist, died May 15, 1994. A 1937 graduate of the University of Sheffield, England, Dr Shapiro was a life member of KMA.

Winston L. Burke, MD
Lexington
1925–1994

Winston L. Burke, MD, a family practitioner, died June 5, 1994. Dr Burke was a 1956 graduate of the University of Louisville School of Medicine, a member of the Governor's Commission for Medical Services, and an active member of KMA.

Taha S. Anvari, MD
Clarksville, IN
1926–1994

Taha S. Anvari, MD, a retired neurologist, died June 26, 1994. A 1950 graduate of the University of Tehran, Iran, Dr Anvari was a life member of KMA.

Keith P. Smith, MD
Corbin, KY
1911–1994

Keith P. Smith, MD, a retired obstetrician/gynecologist, died July 11, 1994. Dr Smith graduated from the University of Louisville School of Medicine in 1936 and had served KMA as Chairman of the Board and Treasurer for a number of years. He was a life member of KMA.

1994

SEPTEMBER

24 — Eleventh Annual Ophthalmology Seminar: Uveitis Update. Audubon Regional Medical Center, Louisville, KY. Contact: Cathy Edens, 240 Audubon Medical Plaza, Louisville, KY 40217; 502/636-2823.

29-October 1 — Lasers in Otolaryngology-Head and Neck Surgery, Vanderbilt University Medical Center, Nashville, TN. Sponsored by Vanderbilt University Medical Center. Contact: Kimberly Sammons, 615/322-4030.

OCTOBER

1 — "Alzheimer's Update: Rhodes Hall Auditorium at The Ohio State University Medical Center. Contact: Sandi Latimer, University Medical Center Communications, 614/293-3660.

28-29 — Laryngeal Video Endostroboscopy, The Village at Vanderbilt, Nashville, TN. Sponsored by Vanderbilt University Medical Center. Contact: Kimberly Sammons, 615/322-4030.

NOVEMBER

2-6 — 88th Annual Scientific Assembly of the Southern Medical Association, Orlando, FL. Contact: Annual Meeting Registration Hotline, 800/423-4992 or FAX, 205/942-0642.



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Hospital Medical Staff Section
24th Assembly Meeting
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Representation Education and Networking

Send a representative from your hospital medical staff and physician organization to the 1994 Interim American Medical Association Hospital Medical Staff (AMA-HMSS) Assembly Meeting held on December 1-5 in Honolulu. Aside from participating in the development of AMA policy, representatives will have an opportunity to network with colleagues, dialogue with the AMA Board of Trustees, and hear the latest news and information on health system reform.

With a changing health care environment, broader diversity within the physician population, limited resources, and an overriding need for unity of purpose and action by organized medicine, the AMA has undertaken a study of the Federation.

Federation Consortium Study

The study, involving county, state and specialty societies, the AMA, and other related organizations, intends to uncover useful information for developing ways to increase membership, member participation, and advocacy as well as improve communications, medical society performance, and resource utilization.

Project leaders have asked the AMA-HMSS to participate in the process because it effectively represents grassroot physician concerns. Input from each HMSS representative also will be extremely valuable in defining organized medicine in the future.

The 1994 Interim AMA-HMSS Assembly Meeting Education Program will host the Consortium study. Data collected and analyzed will facilitate the following objectives:

- Identify current and future needs, expectations, and preference of physicians and others for organized medicine;
- Explore membership ideas and options;
- Assess how medical societies relate to each other—including ways to be more supportive, avoid duplication of effort, leverage strengths, and better address weaknesses;
- Discover whether there are better tools/technologies that medical societies can use to communicate with one another and their members; and
- Enable medical societies to work smart in a more focused and purposeful way.

Plan to participate in the Federation Consortium on Friday, December 3 from 2:30 to 5:30 pm in Honolulu, Hawaii. Mahalo!

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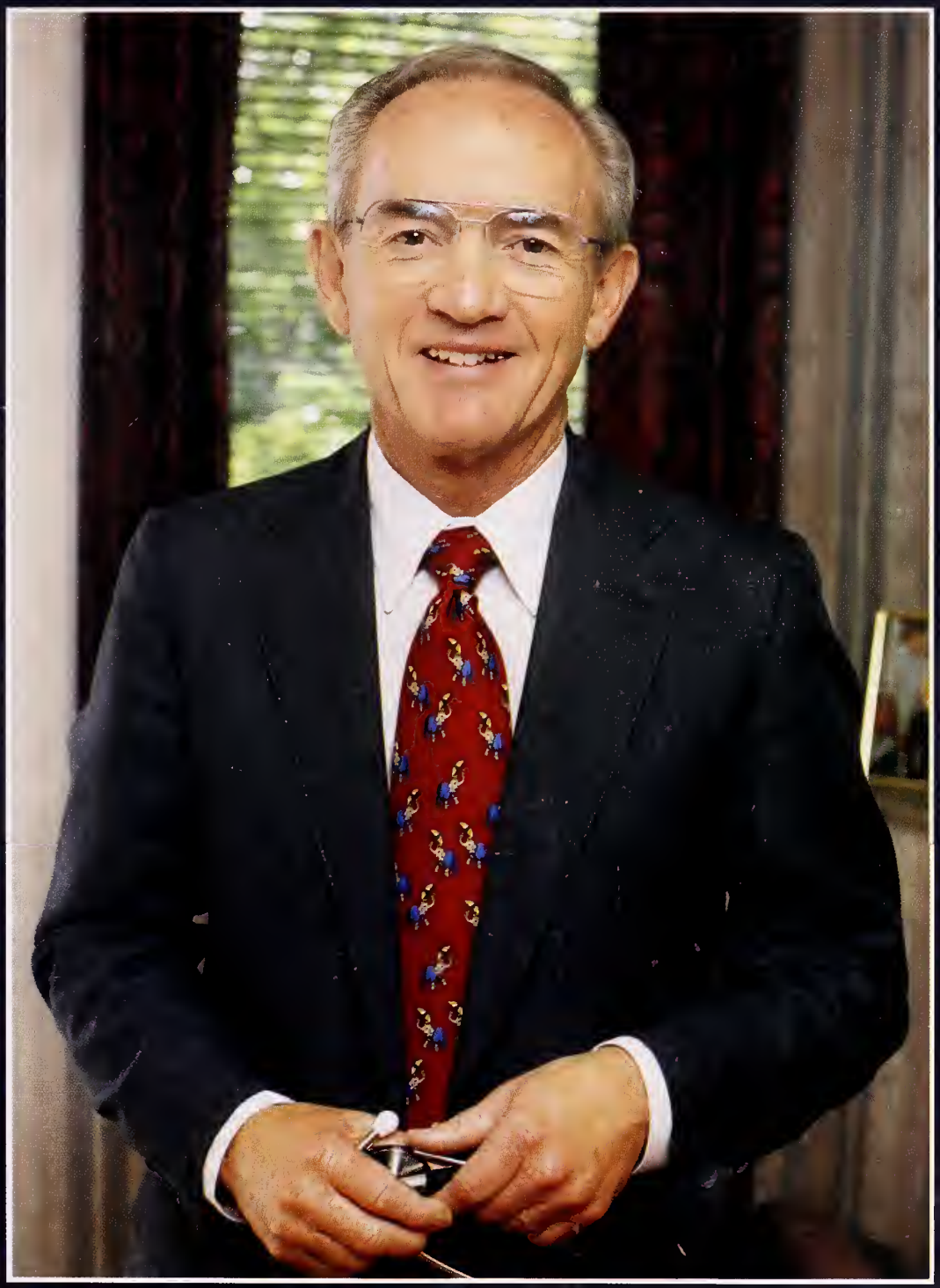
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KMA President 1994-95

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COVER: On September 21, 1994, Robert R. Goodin, MD, o Louisville cardiologist, wos instolled os the 144th President of the Kentucky Medicol Associotion. Dr Goodin's Inougurol Address begins on poge 397.

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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Second-class postage paid at Louisville, KY and additional offices. Yearly subscription rates: $25 domestic; $30 foreign. Single issues $3 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association*, 301 N Hurstbourne Pkwy, Suite 200, Louisville, KY 40222-8512. EDITORIAL AND ADVERTISING: Telephone 502/426-6200.

Listed in Index Medicus. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

National advertising representative: State Medical Journal Advertising Bureau, Inc, 11437 W 106th St, Overland Park, KS 66214, phone 800/788-2360.

The *Journal*, its editors, and the Kentucky Medical Association do not assume responsibility for the opinions and statements of its contributors and advertisers. The *Journal* reserves the right to make the final decision on all content and advertisements.

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Printed by the Ovid Bell Press, Inc, Fulton, Missouri 65251.

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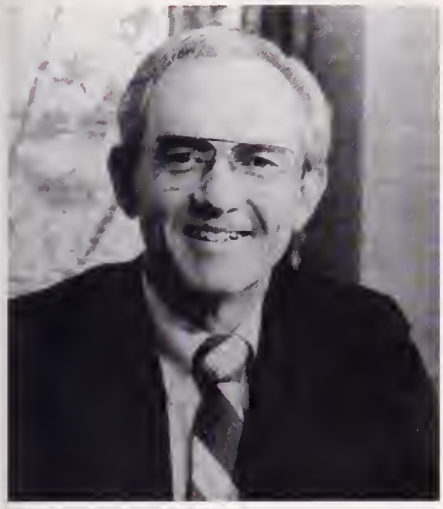
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Inaugural Address

Robert R. Goodin, MD

Is This A Great Profession, Or What?

Thank you very much for affording me this privilege to serve our profession. I wish my folks could have been here today. Dad would have been proud of me, and Mom would have actually believed I *deserve* to be here.

I can't go further without saying thank you to Ardis Hoven. She has done a truly outstanding job for the physicians of Kentucky. In fact, she has given me one hell of a tough act to follow. When this really hit me about 3 months ago, I asked Ardis to serve a second year as your president and simply let me be her assistant, but she wouldn't buy that. So you're stuck with me.

Two major issues clearly dominate our thinking in health care today:

— health system reform — both state and national — and
— managed care delivery systems.

I know you've heard lots about both these subjects over the past several months, so today I want to focus on yet another topic. We'll be dealing with those 2 issues for several years, and KMA has a very strong agenda in place to help us address them.

My theme for next year is "*pride in our profession.*" This strikes me when I see Lee Trevino's Cadillac commercials. In the first one, he reveals that when he was growing up, all he ever saw of a Cadillac was the rear end as he loaded someone else's golf clubs into the trunk. That was during his caddying days, of course. Today he not only owns a Cadillac, but he does the company's commercials. On the opportunity to rise from caddy to owner and promoter, he asks, **"Is this a great country, or what"?** That's how I feel about medicine, so today, I'll borrow his words and ask you, **"Is this a great profession, or what"?**

"The ultimate reason for us to be proud of this profession is the opportunity to serve patients who need our help. Society has truly granted us a unique privilege to practice medicine."

I won't try to convince you that everything is perfect in medicine today. Nor can we expect that the world owes us everything we'd like just because we're caring physicians. That's like assuming a raging bull won't attack you just because you're a vegetarian.

I must admit to waxing a little "Pollyannish" every now and then, but I sincerely believe that what led most of us into medicine remains with us today and bears recalling.

There are many reasons to be proud we're physicians, and I might add, pleased to have our children enter the profession. I have little patience with colleagues who discourage their children from entering medicine, but unfortunately, many are doing just that. Let's look at the positive side:

First, what other profession is more open to anyone who aspires to enter it? I'm a perfect example, having grown up poor on a Central Kentucky farm. My folks had only eighth grade educations, but they held high aspirations for us. We had a two-room country school with outdoor facilities, but like any other student willing to work hard and spend 11 to 14 years in post high school education, I could enter the practice of medicine. Yes, the financial and time commitments are great, but the ultimate rewards are priceless.

Second, we enjoy the privilege of knowing and teaching medical students and residents. Believe me, you don't need to worry about any decline in the caliber of our students, their degree of idealism and commitment, or in the quality of their medical education. Our profession continues to attract the best and the brightest, and I am confident the future of medicine is in very good hands.

Third, I know of no other profession that offers such endless intellectual stimulation and challenge throughout one's career. Medicine is an ever-changing profession that affords us the opportunity for a lifetime of learning. Plus, we work daily with highly intelligent, ethical, and caring colleagues.

Fourth, we can be proud of incredible advances in medicine during the last three decades. Incidentally, it's worth noting that Medicare and Medicaid were enacted 30 years ago. I'm sure many physicians felt then — as many do now — that our profession was doomed by such radical change. Yet we've survived and thrived.

Stop and think just a moment. Some of these major advances have included, for example — in cardiology (my specialty):

— a 35% decrease in mortality from heart attacks
— the development of thrombolytic and other life-saving and life-prolonging drugs
— coronary angioplasty
— coronary artery bypass surgery, and
— cardiac transplantation.

Tremendous advances in other areas include remarkable prosthetic devices for various joints in orthopedics; earlier cancer detection and more effective treatment; laparoscopic surgery with less discomfort and cost. In diagnostic areas, we've seen such remarkable technological developments as CT scanners and magnetic resonance imaging.

I am very proud of the fact that since the inception of the Nobel prize, half of all the Nobel prizes in medicine have been awarded to American physicians. And I might add that not one Nobel prize in medicine has been awarded to a physician in Canada.

"It is easy to forget sometimes — in the midst of long hours or third party hassles — the plight of our patients. But the sick person is in a uniquely dependent, anxious, vulnerable, and exploitable state. The patient and family are in no position to make major decisions about treatment choice or to be concerned about the cost of treatment. These are our defining moments as professionals, when we make the best decisions we can for that patient, and thereby earn and deserve the trust we receive."

Finally, the ultimate reason for us to be proud of this profession is the opportunity to serve patients who need our help. Society has truly granted us a unique privilege to practice medicine.

This leads me to examine how our profession is defined. As you know, the generally recognized "classic learned professions" are the clergy, law, and medicine. Definitions vary greatly, but all definitions of a *professional* embrace the concepts of commitment to both **moral ideals** and **self policing.** Overall, we physicians uphold these professional ideals extremely well. One of my favorite definitions says the essence of being a physician is to treat the sick without concern for:

— who they are
— what their disease is or
— whether they can afford to pay.

While reimbursement may follow treatment, and certainly we couldn't keep our offices open if it didn't, one basic tenet must be that the *"pursuit of material gain is not and must not become the primary goal of the profession."*

We are not technicians. Nor are we providers or gatekeepers. We are physicians. I don't know about you, but I didn't go to provider school. I went to medical school. We must be more than business people and entrepreneurs. We have to continue to embrace our basic moral objectives if we are to maintain the mantel of professional integrity we have gained.

It is easy to forget sometimes — in the midst of long hours or third party hassles — the plight of our patients. But the sick person is in a uniquely dependent, anxious, vulnerable, and exploitable state. The patient and family are in no position to make major decisions about

treatment choice or to be concerned about the cost of treatment. Ladies and gentlemen, these are our defining moments as professionals, when we make the best decisions we can for that patient, and thereby earn and deserve the trust we receive.

To borrow from the words of Judge Elbert Tuttle in his address at the 1957 Emory University Medical School commencement:

"A professional provides service, but that service can't be separated from his personal being. He has no goods to sell and no land to till."

Since the professional gives not only of himself, but also of time, then there is no "right" price for that service. If the service given is bad, then it is worthless; but if it is good, it is priceless. Let us not confuse *the performance of service,* which is great, with the *compensation* — be it money, power, or fame — which is trivial.

Let me share some reflections on a couple of talks by Dr Bob McAfee, President of the American Medical Association and a surgeon from Maine. The following scenarios get at the heart of the altruism that led us into medicine. Please relate these to your specialty because I know you have similar exhilarating moments. Then ask yourself: what other profession could provide such satisfaction?

In Cardiology, we're working progressively longer hours, but the reasons are satisfying because we can actually do a great deal more for patients today than we could 10 years ago. I can't think of a more rewarding opportunity to serve our fellow man than to evaluate and successfully treat the 40-year-old who presents to the ER with one hour of severe chest pain and progressive shock. Terror seizes the patient and spouse, who recognize heart attack and know the outcome can be fatal. Today, through either thrombolytic therapy or emergency coronary angioplasty, we can help this patient survive, salvage heart muscle, and return to a fully normal, productive life with his family, his job, and his community.

There are certainly many good examples of similar satisfying, although stressful times in all medical specialties. Picture the surgeon called into the Emergency Room to take care of the young automobile accident victim who is in shock, and the surgeon quickly evaluates the patient, makes a proper diagnosis of a ruptured spleen, and then appropriately cares for this patient. This is truly life saving medical care. This patient goes from a shock state to being able to look forward to survival and a normal life for many years. Consider the thrill of the obstetrician in assisting the young mother with breech presentation and delivery of a normal healthy baby while maintaining a safe course for the mother. Obviously, primary care physicians meet many new challenges that also provide great rewards and personal satisfaction such as the desperately ill patient with pneumonia who is able to survive because of proper diagnosis and treatment. Certainly the pediatrician can see dramatic results from treating the acutely ill child with bronchiolitis and see the relief of the grateful parents when the child improves so promptly and completely.

"... Since the inception of the Nobel prize, half of all the Nobel prizes in medicine have been awarded to American physicians."

The joy and personal satisfaction we reap from these moments in our medical careers is unparalleled. The gratitude of patients and their families lies beyond explanation to those who haven't experienced it.

You can't quantify the worth of a patient's heartfelt thanks — or even the gratitude of families of deceased patients. There are no CPT codes, no RBRVS values for the priceless rewards we receive. Not to get maudlin, we need to be mindful that we experience the dramatic power of healing on an everyday basis.

Let's guard against losing sight of our real reasons for choosing this most honorable profession. The thrills and rewards remain with us. We have the privilege of sharing our patients' most private and intimate lives. We enjoy a unique and distinct relationship based on trust and respect. May we honor that trust and respect, which we will continue to enjoy — regardless of health system reform — because it is inherent in the nature of our work.

As Dr George Lundberg wrote in 1991, "so may the dedicated physician's every thought be of the patient, and of the patient, and of the patient. That must never change. And let us remember that the enemies of physicians . . . are not the profit-making companies, not the congressional or state politicians, not the government bureaucrats, not the insurance companies, not the hospital administrators, certainly not other physicians. No, not even the attorneys. The enemies of physicians are and will always be premature death, disability, disease, pain, human suffering." These are the enemies of true medical professionals, and combating them generates our greatest challenges and rewards.

Thank you for allowing me to serve.

Presented by
Robert R. Goodin, MD
as he assumed the
Presidency of the
Kentucky Medical Association
on September 21, 1994

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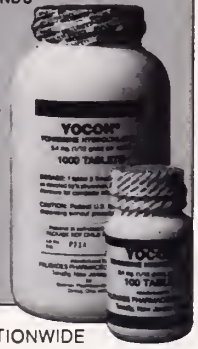
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Meconium Staining: Is It Related to Maternal Smoking?

Terrell Mayes, MD; Jacquelyn Reid, RN, SNM

The present study was undertaken to find if pregnant women's smoking habits were related to the presence of meconium in the amniotic fluid. The medical records of 58 women admitted to the OB service between January 1, 1992, and December 31, 1992, were reviewed. Data from the records was analyzed. Findings indicated that smoking was not related to the presence of meconium in the amniotic fluid. Some women who did not smoke had meconium stained amniotic fluid. Some women who smoked had no meconium staining. A relationship between meconium staining and maternal smoking habits was not supported.

Dr Mayes is in the private practice of obstetrics in Elizabethtown, KY.

Since 1954, it has been recognized that meconium staining, the mixing of meconium with amniotic fluid prior to birth, can negatively influence the neonate's extrauterine adaptation. Meconium complicates birth if it enters the infant's upper respiratory tract. It is hypothesized that the meconium enters the upper respiratory tract during intrauterine hypoxic episodes. It is generally accepted that intrauterine hypoxia falls into three causal categories: altered placental gaseous exchange, altered maternal perfusion of the placenta, or maternal hypoxemia. Any of these events can lead to meconium staining.

Reports of meconium staining's incidence vary from a low of 0.5% to a high of 10%. Korones believes a realistic estimate of meconium staining is from 5% to 10% of all births.[1] It is more likely to occur in term or post-term births and causes low Apgar scores. Meconium staining rarely occurs before 34 weeks. However, investigators have reported sampling meconium stained fluid during second trimester genetic amniocentesis. Fortunately, less than half the infants with meconium stained amniotic fluid aspirate meconium below the vocal cords.

Creasy and Resnik discussed three hypotheses of meconium passage in utero: the maturation theory, the intestinal hormone theory, and the fetal distress theory.[2] The maturation theory is based upon research in guinea pigs. Researchers observed radiopaque dye instilled in the pregnant guinea pig's amniotic fluid enter the gastrointestinal tracts of the fetuses. As their GI tracts matured, fetuses routinely passed meconium into the amniotic fluid. Scientists propose that as the GI tract ganglia mature, meconium passage may occur as a natural course. The increased occurrence of meconium staining in post-term infants supports this theory. The second theory is based upon the appearance of motilin, a hormone that acts on the GI musculature. Levels of motilin in the umbilical cord venous plasma were elevated in eight infants with abnormal fetal heart rate patterns, five of whom passed meconium in utero.[3] The final theory of meconium passage, that of fetal distress, is supported in multiple studies and is discussed in the next section. As with many physiological mechanisms, the cause is probably a combination of all three processes.

The fetal distress theory of meconium staining is a response to intrauterine hypoxia. The mechanism of meconium release is complex and theoretical. Increased peristalsis and relaxation of the anal sphincter in response to fetal hypoxia result in meconium incontinence.[4] Fetal motion and fluid currents mix meconium with the amniotic fluid. Once amniotic fluid is stained, the stage for meconium aspiration is set. If repeated hypoxic events occur, the fetus gasps, drawing meconium stained amniotic fluid into the mouth and nares. At birth, when the infant inspires, meconium in the mouth and nares is aspirated below the vocal cords into the lungs. There it blocks bronchioles, trapping air and over inflating distal alveoli. CO_2 retention, hypoxemia, and acidosis result. Meconium triggered epithelial inflammation leads to chemical pneumonitis. Decreased gaseous diffusion, increased airway resistance and decreased lung compliance ensue. The vicious cycle of hypoxia and acidosis can lead to persistent pulmonary hypertension.[5]

In summary, meconium staining is a significant finding in the intraparietal period with consequences for the birth setting that reach beyond the time of birth and contribute to perinatal morbidity and mortality.

Researchers have explored a variety of variables that contribute to meconium staining throughout gestation and findings are conflicting and confusing. Among them are high-risk pregnancies, postdatism, elective induction of labor and unhealthy habits. High-risk pregnancies complicated by diabetes mellitus and hypertensive disorders, both of which may contribute to fetal hypoxia, have increased incidence of meconium staining.[6] In 1992, Herabutya, et al, redocumented that women with postdates pregnancies who were allowed to await spontaneous onset of labor had greater rates of meconium staining than women who were induced for postdates.[7] In yet another study, elective induction was a documented factor associated with meconium staining.[8] Recently, Johnson, Longmate and Frentzen reported that excessive maternal weight gain and meconium staining were associated.[9]

Since 1957, when Simpson documented that smoking had negative effects on pregnancy outcome, many studies of smoking's influence on pregnancy have been conducted. A well documented body of literature indicates that gravid smokers are at risk for four types of poor pregnancy outcome: low birth weight, spontaneous abortion, preterm birth and placental abnormalities. Smoking habits also have been associated with meconium staining. Marijuana smoking has a demonstrated relationship to meconium staining.[10] However, findings of studies on tobacco smoking and meconium staining have not supported an empirical relationship.[11] If knowledge about the influence of tobacco smoking on placental blood vessels is taken to a logical conclusion, it can be inferred that maternal smoking could produce adequate placental underperfusion to cause fetal hypoxia and meconium staining.

At present there are no measures to prevent meconium staining because it results from physiologic mechanisms that health care providers cannot control. However, identification of women at risk for meconium staining is enhanced by amniotic fluid index (AFI).[12] In a study of AFIs and outcome of delivery, the researchers found that infants of women with greater than 50% of their amniotic fluid in the upper quadrants of the uterus had increased meconium staining, lower Apgar scores at 1 minute, non-reassuring fetal heart rate patterns, increased rates of C-sections and lower umbilical venous pHs. The approach to meconium staining is to prevent a serious complication that follows staining — meconium aspiration. There are two approaches to the prevention of meconium aspiration: amnioinfusion and DeLee suctioning of the neonatal nares and mouth immediately after delivery of the head and before delivery of the thorax, followed by visualization of the cords with a laryngoscope if respiratory distress is present.

Amnioinfusion therapy was developed in the mid 1980s. It was designed for use in cases where inadequate amniotic fluid results in fetal distress signaled by unremitting variable decelerations.[13] Amnioinfusion provides replacement of amniotic fluid in cases where there is decreased volume: premature rupture of membranes, intrauterine growth retardation or postdates gestation. More recently amnioinfusion has been used to reduce the concentration of meconium in stained amniotic fluid.[14] This greatly reduces the likelihood of significant meconium below the vocal cords and the incidence of neonatal acidemia.[15]

Carson proposed DeLee oro-nasopharyngeal suctioning after delivery of the head, and before delivery of the shoulders and thorax.[16] After delivery was complete, the infant was handed to a pediatrician for direct laryngoscopy of the cords. If meconium was visualized at the cords or below, suctioning was performed. The two study findings of significance were that obstetrician suctioning greatly reduced the presence of meconium at or below the vocal cords and meconium aspiration was dramatically reduced. In 1988, Linder et al, studied infants delivered from meconium stained amniotic fluid who had no signs of respiratory distress.[17] They demonstrated increased morbidity following unnecessary suctioning. From these studies, recommendations on treating meconium staining to prevent meconium aspiration are to perform DeLee suctioning of the nares and oropharynx, and if respiratory distress is evident, laryngoscopic suctioning of the airways.[18]

Signs and symptoms of meconium staining are evident when the amniotic sac is ruptured either spontaneously or artificially. Staining varies from light to thick. There is disagreement about the influence of light or thick meconium on the outcome of birth. Findings of research conflict. Some report no difference in outcome based upon Apgars, fetal scalp pHs or fetal heart rate patterns.[19, 20, 21, 22] Others reported lower Apgar scores and fetal scalp blood pH values in the presence of thick meconium.[23] The problem is further confounded by the lack of objective means to evaluate degrees of meconium staining. Logic leads one to assume that the potential for

respiratory distress would be higher in the presence of thick meconium in labor.

Predicted outcomes of meconium staining are inconsistent. The majority of research documents no significant difference in Apgars, measures of acidosis or fetal heart rate patterns between infants with clear amniotic fluid at birth and those with meconium stained fluid. There is little reason to believe that meconium stained fluid is an ominous finding in the presence of a reassuring fetal heart rate pattern. Further there is adequate empirical evidence to support oropharyngeal suctioning of the neonate with delivery of the head and notification of the pediatrics staff that the infant may need resuscitation.

As already stated, the connection between smoking and meconium staining has not been empirically documented. This retrospective, chart review based study was undertaken to explore the relationship of smoking to meconium staining. The setting is a rural population in Kentucky, a state which has an economy at least partially dependent upon tobacco abuse. Continued smoking in pregnancy is associated with age, marital status, socioeconomic status and education.[24] Therefore these variables were included in the data collection.

A review of the birth book produced 556 births in 1992 in this practice. Fifty-eight entries documented meconium stained amniotic fluid upon spontaneous or artificial rupture of membranes. The medical records of the 58 women were reviewed to obtain information for this study. Three of the 58 labors (5%) resulted in cesarean sections, 55 labors (95%) culminated in vaginal delivery. This is equal to the ratio of vaginal to cesarean births present in this nurse-midwife/physician practice. The degree of meconium staining was collected from the medical record. Grading of staining was based on three degrees: light, moderate or heavy. Light meconium staining occurred in 31 (53.4%) cases, moderate meconium staining presented in 8 (13.8%) cases, and there was heavy meconium staining in 19 (32.8%) cases.

Information on smoking habits was collected from four sources: the initial history upon entry to prenatal care, the interim history during each prenatal visit, the nursing history upon admission to the hospital and the admission history by the health care provider. As could be predicted, there was not always agreement among the four sources. Some reported smoking at the onset of prenatal care, then reported they had stopped as care progressed. On admission, the history would reflect a 1.2 pack-a-day smoking habit. The decision was made to count anyone who reported smoking upon admission to the nurse or health care provider as a smoker. Conversely, persons who reported no smoking during the admission interview to the nurse or health care provider were counted as nonsmokers. This decision was based upon the findings of Fox who evaluated accuracy of smoking self-reports against salivary thiocyanate (SCN) levels.[25] Their research indicated a moderate degree of correlation between SCN levels and self-reports of smoking. Of the 58 subjects, 38 (65.5%) were classified "nonsmokers"; 20 (34.5%) were classified as smokers. It is interesting to note that the percentage of smokers (34.5%) closely parallels the prevalence of smoking in women nationwide.

Subject characteristics retrieved from the records included age, gravidity, parity, gestational age at delivery, infant gender, Apgars at 1, 5, and 10 minutes, birth weight, and presence or absence of nuchal cord. The ages of the subjects ranged from 15 to 41 years, with a mean of 24.32 years. A summary of the remaining characteristics are contained in Table 1.

Table 1. Characteristics of Subjects

	N	%		N	%
Gravida			Parity		
1	21	36.2	0	29	50.0
2	15	25.9	1	14	24.1
3	11	19.0	2	7	12.1
4	6	10.3	3	4	6.9
5	3	5.2	4	2	3.4
8	2	3.4	6	1	1.7
			9	1	1.7
EGA				Weight at Birth (Gms)	
34	1	1.7	<3000	6	10.2
36	1	1.7	3000-3999	43	73.1
38	3	5.2	>4000	9	15.3
39	10	17.2			
40	28	48.3	Gender		
41	14	24.1	Boys	29	50.0
42	1	1.7	Girls	29	50.0
Apgar 1 (1 minute)			Apgar 2 (5 minutes)		
2	1	1.7	4	1	1.7
5	2	3.4	7	1	1.7
6	6	10.3	8	7	12.1
7	14	24.1	9	45	77.6
8	29	50.0	10	4	6.9
Apgar 3 (10 minutes)			Nuchal Cord		
8	1	1.7	No	17	29.3
9	1	1.7	Yes	41	70.7
10	1	1.7			
9	6	10.3			

A chi-square was performed to examine the relationship between smoking and meconium staining. The chi-square value achieved was not significant at the $p = 0.5$ level. Therefore, no relationship was revealed between smoking and meconium staining.

A chi-square was performed to explore the relationship between EGA and meconium staining. The chi-square value achieved revealed no relationship between EGA and meconium staining in these subjects.

To evaluate the relationship between nuchal cord and meconium staining, a third chi-square was performed. There was no significant relationship between nuchal cord and meconium staining.

To measure the influence of meconium staining upon the Apgar, a chi-square between the 1 minute Apgar and presence or absence of meconium staining was performed. No significant relationship was revealed between the first Apgar and meconium staining. Because all 5 and 10 minute Apgars were higher than 1 minute Apgars, there was no reason to evaluate the relationship between those Apgars and meconium staining.

Finally, to find if the amount of meconium staining influenced the 1 minute Apgar, the degree of staining was included in the calculation. No significant relationship was found between degree of meconium staining and initial Apgar.

In summary, the findings of this study support previous research findings that no direct relationship exists between smoking and meconium staining. Further, no relationship was found between gestation 41 weeks and beyond and meconium staining. This relationship has been reported in previous studies. In this study, only one-fourth of those experiencing meconium staining were 41 weeks or beyond. The small number of postdates pregnancies may be responsible for the finding.

No relationship existed between nuchal cord and meconium staining. Presence of meconium in the amniotic fluid was not related to 1 minute Apgar. Finally, amount of meconium was not correlated with the Apgar score at 1 minute. Findings of this study support those of previous studies.

Completion of this study has raised more questions than have been answered. Meconium staining is obviously a phenomenon that arises from many causes, however its influence on the infant in the immediate period after delivery is not easily measured. Further research with a larger number of smoking subjects may add more to the knowledge about the basis for its occurrence. Information also needs to be collected on the mother's home environment. How many individuals there smoke? There is little information on the influence of side-stream smoke on pregnancy. This study was retrospective. Future research should be prospective, including tests such as urine cotinine levels to verify smoking for greater accuracy in data. Additionally, more careful evaluation of amount of meconium staining could be obtained during a prospective study. Data such as paternal smoking pattern might be added to the study design.

The importance of meconium staining research is evident. Only by understanding events that precipitate its occurrence and the effects of therapies designed to prevent its aftermath can a safe delivery be rendered.

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The Use of Exogenous Surfactant Replacement Therapy in Newborns with Non-respiratory Distress Syndrome Conditions

Dan L. Stewart, MD

From the Division of Neonatal Medicine, Department of Pediatrics, University of Louisville Schaol of Medicine, Louisville, KY. Reprint requests ta Dan L. Stewart, MD, Divisian af Neanatal Medicine, Department af Pediatrics, Louisville, KY 40292.

Surfactant replacement therapy for premature infants born with inadequate stores of pulmonary surfactant is the accepted standard of care and is here to stay. An increasing number of prospective, randomized, controlled clinical trials verify both the efficacy and safety of tracheal installation of liquid surfactant in treating premature infants with respiratory distress syndrome (RDS).[1] (Table) This article reviews the current recommendations from the Committee on Fetus and Newborn for the use of replacement surfactant in RDS and explores the use of surfactant in non-RDS conditions diagnosed in neonatal medicine.

Composition/Metabolism/Properties

Surfactant phospholipids are synthesized in the smooth endoplasmic reticulum of granular (Type II) pneumocytes that line the air spaces. At about 24 weeks gestation in the human, many cuboidal cells differentiate into granular pneumocytes and develop an abundant apparatus for synthesis, packaging, and storage of surfactant. After secretion, surfactant phospholipid is also taken back into the granular pneumocytes by endocytosis, forming multivesicular bodies, which are rapidly incorporated into lamellar bodies before being secreted again. Surfactants may be reutilized in this fashion 10 times before being degraded.[2]

Lung surfactant is a complex mixture consisting of 80% to 90% lipids and 10% to 20% proteins. The major surface active component of surfactant is dipalmitoyl phosphatidylcholine (DPPC); however, DPPC alone is not a functional pulmonary surfactant in vivo. One or more anionic phospholipids is essential to activate it. Although phosphatidylglycerol (PG) is the predominant anionic phospholipid in mammalian lung surfactant, surfactant function remains unchanged if PG is largely replaced by either of the anionic phospholipids, phosphatidylinositol or phosphatidylserine. Of the proteins obtained from a bronchoalveolar lavage, 80% are serum protein contaminants. Surfactant apoproteins comprise 2% to 4% of purified lung surfactant with SP-A being the most plentiful. The synthesis of SP-A is developmentally regulated and is glucocorticoid responsive. SP-A is important because it participates in regulation of lung surfactant production.[3]

The insoluble phospholipids of the alveolar lining layer have at least four major functions: (1) to stabilize the lung during deflation, (2) to prevent high surface tension pulmonary edema, (3) to protect the lung against epithelial damage, and (4) to provide a defense against infection.

Insufficiency of lung surfactant results in respiratory distress syndrome, also known as hyaline membrane disease. RDS was the leading cause of death in prematurely born infants in the past, but now has been replaced by congenital anomalies. During the 1970s and 1980s, RDS accounted for between 5,000 and 10,000 deaths even before the advent of surfactant replacement therapy.[1] Since RDS is no longer the leading cause of death in premature infants, deaths from RDS should continue to decline with the increasing use of surfactants. Surfactant is not a panacea for all infants with respiratory distress and several practical questions about surfactant replacement remain unanswered. These include the optimal preparation, qualifying criteria, prophylactic versus rescue therapy, timing of administration of subsequent doses, quantity of dose, and total number of doses. These questions should be clarified in the future as more information is generated with clinical trials.

Future Directions in Surfactant Replacement Therapy

The critical role of lung surfactant in maintaining alveolar stability and lowering the work of breathing is well established. Surfactant replacement results in improved oxygenation, a reduction in

Table 1. Typical Odds Ratias and 95% Canfidence Intervals far the Effects af Surfactants in Praphylaxis and Treatment Trials

	Natural Surfactant			Synthetic Surfactant		
	Na. af Trials	Odds Ratia	95% Canfidence Intervals	Na. af Trials	Odds Ratia	95% Canfidence Intervals
Praphylaxis						
Neanatal death	9	0.55	0.38-0.80	7	0.65	0.50-0.86
Pneumatharax	9	0.31	0.22-0.44	3	0.62	0.40-0.96
Branchapulmanary dysplasia	6	0.59	0.40-0.86	6	0.99	0.75-1.31
Death ar branchapulmanary dysplasia	6	0.43	0.30-0.63	3	0.84	0.64-1.09
Treatment						
Neanatal death	13	0.60	0.47-0.76	5	0.61	0.46-0.80
Pneumatharax	12	0.34	0.26-0.43	4	0.71	0.50-1.00
Branchapulmanary dysplasia	8	0.94	0.64-1.39	4	0.71	0.50-1.00
Death ar branchapulmanary dysplasia	9	0.61	0.45-0.84	3	0.56	0.45-0.72

An adds ratia less than 1 suggests that the treatment is superiar ta cantral. An adds ratia mare than 1 suggests that it is inferiar. If the 95% canfidence interval daes nat include zera, the difference is statistically significant.

Adapted fram: Halliday HL. 1991. Surfactant replacement. In: Yearbaak af Neanatal and Perinatal Medicine. MH Klaus and AA Fanaraff, XIII-XXI, eds. St. Lauis; Masby Yearbaak.

mechanical ventilation requirements, a shortened average duration of hospitalization, and in some studies improved survival. Surfactant inactivation has shown to be a significant factor in animal models of lung injury and may be an important factor in some forms of respiratory failure in full-term newborns. The success of surfactant replacement therapy for respiratory distress syndrome has increased interest in extending this approach to treat lung injuries in which endogenous surfactants may become deficient or inactivated.

A number of investigations have implicated pulmonary surfactant dysfunction in several respiratory diseases or injuries that lead to the general pathology of adult respiratory distress syndrome (ARDS). Edema constituents, such as plasma proteins, hemoglobin, and cellular lipids, have been shown to inhibit the biophysical activity of pulmonary surfactant in vitro. The use of exogenous surfactant replacement therapy has proved beneficial in several of the animal models of adult respiratory distress syndrome.

Many of the pathologic changes in ARDS are similar to those found in neonates with respiratory failure as a result of meconium aspiration syndrome (MAS) and pneumonia. In a recent study by Auten et al,[4] a total of 14 infants were treated with exogenous surfactant (seven infants had MAS and seven infants had pneumonia). Of the 14 patients treated, none died, required extracorporeal membrane oxygenation (ECMO), developed tension pneumothorax after study entry, required oxygen supplementation for more than 14 days, or required oxygen supplementation at discharge. This study would suggest a therapeutic benefit for newborns with respiratory failure due to pneumonia or meconium.

Infants with respiratory failure as a result of other primary diseases or postnatal lung injury can also experience surfactant deficiency. Many of the infants with respiratory failure will require the additional support provided by ECMO. A recent study conducted by Lotze et al[5] at Children's National Medical Center evaluated the use of multiple-dose surfactant therapy as related to pulmonary outcome. Infants ≥34 weeks gestation in severe respiratory failure on ECMO were stratified by diagnosis and then randomized. Four doses of air or modified bovine lung surfactant extract (beractant) were administered. They demonstrated that the use of a multiple dose surfactant regimen in term infants in respiratory failure was associated with shortened time on bypass, improved pulmonary mechanics, increased endogenous SP-A content, and decreased post-ECMO morbidity.

As a result of the pilot study done by Lotze et al a national study has been undertaken to evaluate the use of beractant (Survanta) in infants who have respiratory failure with the diagnosis of meconium aspiration syndrome, sepsis, or pri-

mary pulmonary hypertension. This blinded, controlled, randomized study will be conducted in 16 ECMO centers and involve 1000 patients. The hypothesis is that correcting the surfactant deficiency may improve the disease state and avoid the need for ECMO; but if the infants progress to ECMO, hopefully it will shorten the duration of support and avoid associated complications. This is an exciting study that may impact how replacement surfactant is used in the future.

Case Presentations

The following are two examples of the use of surfactants in nontraditional methods in our neonatal intensive care unit.

Case 1[6] — This 2-kg male infant was born at 34 weeks of gestation to a 28-year-old gravida 2 para 1 mother by spontaneous vaginal delivery. The mother had a history of previous genital HSV lesions, but no lesions were noted during the pregnancy or at delivery. Maternal membranes ruptured 6 hours before delivery. The Apgar score was 9 at both 1 and 5 minutes. The transition from fetal to neonatal circulation was uneventful. The infant was discharged to home on Day of Life (DOL) 2 as a well baby.

On DOL 5 the infant developed respiratory distress. The physical examination at that time was significant for an afebrile infant with a respiratory rate of 100 breaths/minute, cyanosis, poor perfusion and rales. There were no skin, eye or mouth lesions consistent with HSV infection and the liver was not enlarged. The laboratory evaluation revealed a peripheral white blood cell count of 2400 cells/mm^3 with 22% band forms, 18% segmented neutrophils, 48% lymphocytes and 10% atypical lymphocytes. The platelet count was normal. A chest radiograph revealed diffuse infiltrates (See Fig 1). A nasal wash specimen was tested for respiratory syncytial virus antigen by enzyme-linked immunosorbent assay and for *Chlamydia trachomatis* by immunofluorescence and both were negative. Group B streptococcal antigen was not detected by latex agglutination. The cerebrospinal fluid showed 1 white blood cell/mm^3, 4 red blood cells/mm^3, a protein concentration of 96 mg/dl and a glucose concentration of 82 mg/dl. The total bilirubin concentration was 11.4 mg/dl and direct fraction was 0.4 mg/dl. Liver transaminases were slightly elevated; alanine aminotransferase 58 IU/liter, gamma-glutamyltranspeptidase 66 IU/liter. Ampicillin and gentamycin therapy was administered.

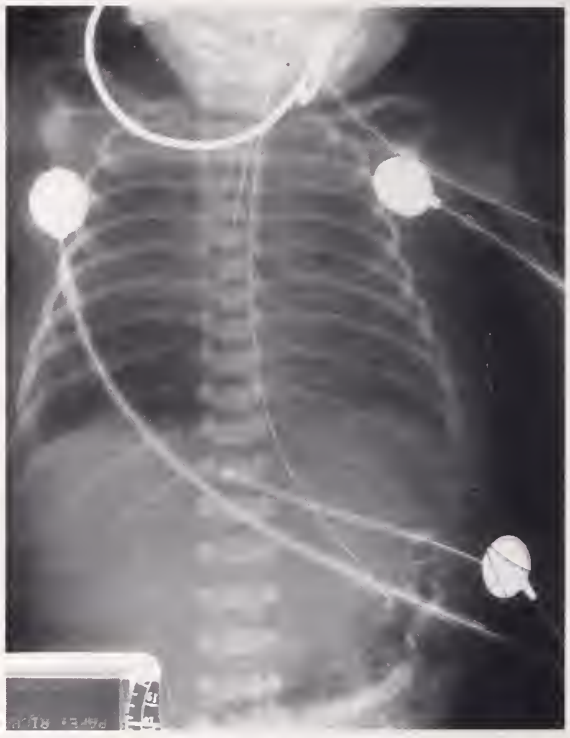


Fig 1 Chest x-ray of infant with diffuse bilateral pneumonitis.

During the first 6 hours after admission the infant required increasing respiratory support progressing from an "oxyhood" to maximal mechanical ventilation with the use of high frequency ventilation on the Sensormedics® oscillator with 100% oxygen, a mean pressure of 26 cm of water and a delta pressure of 60 cm of water. After the initiation of ventilatory support, a gram-stain of a tracheal aspirate showed a few white blood cells, a few epithelial cells, and there was no growth from the bacterial culture. The infant's respiratory status stabilized on high frequency ventilation, but further deterioration on DOL 8 resulted in the infant's being managed with ECMO when the oxygenation index (fraction of inspired oxygen $\times$ mean airway pressure $\times$ 100/$Pa0_2$) reached 54. Most ECMO centers use an oxygenation index of greater than 40 as the criterion for initiation of ECMO. Because of progressive pneumonitis during antibiotic administration, negative bacterial cultures of blood, urine, cerebrospinal fluid and endotracheal secretion and a history of recurrent maternal genital HSV infection, viral cultures were obtained on DOL 8 and therapy was empirically started with acyclovir at

10 mg/kg/dose intravenously every 8 hours and continued for 21 days. HSV type 2 was recovered from endotracheal secretions on DOL 10.

The infant's ECMO course was prolonged (DOL 8 to 28) and complicated by two nosocomial infections and a mild left middle cerebral artery infarction. Weaning from ECMO was potentiated by use of exogenous surfactants on DOL 21 and DOL 23. Pulmonary compliance improved and resistance decreased. He was weaned from ECMO on DOL 28, but required ventilator support until DOL 46.

Case 2 — This is a 3.4 kg male infant born at 38 weeks of gestation to a 32-year-old gravida 2 para 1 mother by spontaneous vaginal delivery. The pregnancy, labor, and delivery were uncomplicated. Rupture of membranes was 7 hours prior to delivery. Apgar scores were 8 at 1 minute and 9 at 5 minutes. The transition from fetal to neonatal circulation was uneventful.

The infant remained asymptomatic until approximately 4 hours of age when he developed mild respiratory distress. Chest x-ray (CXR) revealed a right lower lobe infiltrate and a small right pleural effusion. Complete blood count revealed a white blood cell count of 3,100 cells/mm^3 and a platelet count of 202,000. Infant was started on oxygen per nasal cannula at 1 liter/minute. A septic workup was done and ampicillin and gentamycin were started. Transfer was arranged from intermediate care nursery to an intensive care nursery.

On Day of Life (DOL) 1, the infant required assisted ventilation and vasopressor support with dopamine for hypotension. Blood culture was positive for group B Beta hemolytic streptococcus (GBS). Infant was given intravenous gammaglobulin (IVIG) for neutropenia. Heart echo showed 3 mm/sec of tricuspid regurgitation with a patent ductus arteriosus. This was felt to represent PPHN (persistent pulmonary hypertension) complicating a GBS pneumonia.

On DOL 3, conventional ventilator settings had escalated to FiO_2 72%, peak inspiratory pressure (PIP) of 28 centimeters of water, peak end expiratory pressure (PEEP) of 4 centimeters/H_2O, and a rate of 60 breaths/minute. A dose of artificial surfactant (5 cc/kg) was administered intratracheally. After some initial instability, the infant weaned to FiO_2 — 60 percent, PIP — 26, PEEP — 4, and a rate of 50. On DOL 4, the infant's CXR was interpreted as normal, and PFT's (pulmonary function test) showed that the dynamic compliance was .42 ml/cm H_2O/kg. Infant was extubated on DOL 7, and was discharged to home after completion of 14 days of antibiotics.

This infant's rapid improvement from GBS pneumonia certainly was accelerated by the use of artificial surfactant.

Cost Effectiveness of Exogenous Surfactant Replacement

At this point, the issue of cost effectiveness can not be analyzed in our blinded study using exogenous surfactant in conjunction with ECMO, but cost implications for hospital charges for premature infants with respiratory distress syndrome has been evaluated. Maniscalco et al found that average daily hospital charges in the surfactant treated patients were 25% less than for the control patients. Most of the savings in daily hospital charges were due to a 52% reduction in daily charges for laboratory, x-ray, respiratory therapy, and other ancillary services.[7]

Therefore, surfactant replacement therapy not only decreases morbidity and mortality for RDS, but reduces charges from ancillary services. This certainly overshadows the cost of treatment which consists of treatment with 5 cc/kg aliquots being given intratracheally on two or three separate occasions. The cost of one brand of exogenous surfactant is $727 per 8cc vial in our intensive care nursery. Despite the cost incurred with multiple treatments, exogenous surfactant should prove cost effective in the larger infants with non-RDS conditions as has been the case in the premature with RDS.

Current Recommendations

Although published data indicate that lung surfactant replacement therapy is both effective and safe when used to treat infants with hyaline membrane disease, caution is still in order when considering use of these agents outside protocols since wide experience is not available. Until further experience is obtained, the recommendations of the Committee on Fetus and Newborn[8] should be as follows:

1. The surfactant replacement therapy should be conducted by physicians qualified and trained to do so. Qualifications should include experience in the respiratory management of low birth weight infants, including knowledge and experience in mechanical ventilation.
2. Nursing and respiratory therapy personnel

experienced in the management of low birth weight infants, including mechanical ventilation, should be available on site when surfactant therapy is administered.
3. Equipment necessary for managing and monitoring low birth weight infants, including that needed for mechanical ventilation, should be available on site when surfactant therapy is conducted.
4. Radiology and laboratory support to manage a broad range of needs for very low birth weight infants should be available.
5. There should be an institutionally approved surfactant therapy protocol, which should be a mandatory component of the quality assurance program.
6. When any of the items in recommendations 2 through 5 are not present, if an emergency situation arises and if indications are present, the surfactant therapy may be given, but only by a physician skilled in endotracheal intubation. Infants should be transferred from such institutions as soon as feasible to a center with appropriate facilities and staff trained to care for multisystem morbidity in low birth weight infants.

Conclusion

Surfactant therapy is a national treatment strategy that is based on sound physiologic principles and extensive experimental and clinical testing.[9] Research should confirm other uses of replacement surfactant therapy after completion of adequate double blinded studies.

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Congenital Cytomegalovirus Disease in the Louisville Area: A Significant Public Health Problem

John Buchheit, MD; Gary S. Marshall, MD; Gerard P. Rabalais, MD; James G. Dobbins, PhD

Using a passive surveillance system, 15 cases of symptomatic congenital cytomegalovirus (CMV) infection were identified in the Louisville area over approximately 3 years. When compared to mothers delivering healthy infants in Jefferson County, mothers of infants with congenital CMV were younger, more often nonwhite, and from lower socioeconomic status. Affected infants had a lower mean gestational age and birth weight, and most demonstrated classic features of congenital CMV infection such as jaundice, petechiae, hepatosplenomegaly, intrauterine growth retardation, and microcephaly. The overall infant mortality rate was 33%. Maternal and infant characteristics were similar to those of 167 cases in a national database and 106 cases reported from Birmingham, Alabama. The estimated minimal incidence of symptomatic congenital CMV disease in this area was 1.16/10,000 live births for white and 6.06/10,000 for nonwhites, establishing this as a significant public health problem in this part of Kentucky.

Cytomegalovirus (CMV), a ubiquitous human herpesvirus, is the most common cause of intrauterine fetal infection in the United States. It has been estimated that 1% of all live-born infants are congenitally infected with CMV, currently amounting to some 40,000 cases per year.[1,2] Of these, approximately 10% manifest clinical and laboratory abnormalities at birth and go on to experience devastating sequelae such as neurodevelopmental delay, blindness, deafness, and premature death. Of the remaining infants with no demonstrable signs of infection at birth, as many as 15% may develop late sequelae, particularly sensorineuronal hearing loss. In all, 8,000-10,000 children in this country may suffer significant consequences of intrauterine CMV infection each year.[2] This disease burden is comparable to that resulting from invasive *Haemophilus influenzae* infection prior to the vaccine era and carries an annual estimated cost of $1.86 billion.[3]

In response to this disease burden, a National Cytomegalovirus Registry was established in January 1990 in collaboration with the Centers for Disease Control and Prevention (CDC).[4] Data on symptomatic infected infants have been passively collected at centers throughout the country in order to characterize trends over time, define the natural history of the disease, identify risk groups, and establish a foundation for future public health interventions (an analysis of the first 100 cases was recently published).[3] As a participating study center, we have collected data on regional cases identified by passive surveillance over approximately 3 years; to our knowledge, this constitutes the first systematic database on congenital CMV disease in Kentucky. This paper serves to summarize clinical and demographic data on these cases and to compare them to the national database and to the published experience in Birmingham, Alabama.[5]

Methods

The Division of Pediatric Infectious Diseases at the University of Louisville constitutes the only specialty group in pediatric infectious diseases in the western half of Kentucky. Based at Kosair-Children's Hospital, the major regional pediatric and neonatal referral center, the division is referred or informed of most newborns with suspected congenital infection who enter the regional medical system. In order to increase case ascertainment, our interest in CMV and participation in the national study was publicized through lectures, seminars, and a widely distributed medical newsletter ("Cultured Comments"). It was assumed that in Jefferson County and adjacent counties (Oldham, Shelby, Spencer, Bullit, and Hardin), case ascertainment would be relatively complete, whereas it was recognized that in more distant counties, symptomatic infants might be referred elsewhere. In addition, as with any passive surveillance system, some infants with mini-

Dr Buchheit is in the Division of Neonotology ond Drs Morsholl ond Robolois ore in the Division of Pediotric Infectious Diseoses, University of Louisville School of Medicine, Louisville, KY. Dr Dobbins is in the Division of Virol ond Rickettsiol Diseoses, Centers for Diseose Control ond Prevention, Atlonto, GA.

Address correspondence to Deportment of Pediotrics, Division of Infectious Diseoses, University of Louisville School of Medicine, Louisville, KY 40202 (Dr Morsholl).

mal symptoms might go unrecognized. Kentucky birth statistics were obtained from the 1990 Vital Statistics Report (Department for Health Services, Division of Vital Records, Frankfort, KY), and follow-up information on patients was obtained from medical records and from telephone discussions.

Twenty-six other centers participated in national surveillance. Clinical and demographic information was collected on standardized forms and archived at the CDC; data on cases registered between January 1, 1990 and December 31, 1992, were analyzed. Cases were considered "confirmed" if they were culture-positive in the first 3 weeks of life and had one or more clinical or laboratory abnormalities, outlined in Table 1. Cases were considered "possible" if the clinical findings were suggestive of congenital disease but the virus was isolated between 3 weeks of life and 1 year.

A regional control group was developed by collecting data on 100 consecutive deliveries at each of 3 obstetrical hospitals in Jefferson County in 1992. Together, these hospitals account for 67% of annual deliveries in the county. The first hospital is located in an urban setting and has a service base with mixed demographic features. The second is suburban in location and predominantly serves white, privately insured patients. The third is an inner-city university teaching hospital which predominantly serves an indigent population. It was felt that this sample would reflect the clinical and demographic features of a cross-section of mothers and infants in the region. Although congenital CMV infection was not rigorously excluded in these infants, none had clinical features to suggest that diagnosis. It is recognized that this control group may not reflect the population delivering infants outside of Jefferson County.

Regional cases were compared to the regional comparison group and to national cases excluding those contributed from Birmingham, Alabama. In the above analyses, differences in proportions were tested for significance ($p < 0.05$) using Fisher's exact test. Differences in means were tested using the t test; when sample variances were significantly different by the F variance ratio test, the Mann-Whitney U statistic was used. Regional data were also compared to published data from a longitudinal study spanning

Table 1. Notional Registry Case Definition

Cytomegolovirus isolotion in the first 3 weeks of life	
-AND-	
One or more of the following:	
petechiae or purpuro	*hearing impoirment*
hepotomegoly	*chorioretinitis*
splenomegoly	*seizures*
joundice at birth	*smoll for gestotionol age*
hemolytic onemio	*plotelet count <75,000/uL*
introcroniol colcificotions	*direct bilirubin >3 mg/dL*
microcepholy	*olonine ominotronsferase >100 U/L*
other neurologic abnormalities	

Table 2. Symptomotic Congenitol Cytomegolovirus Infection

	Louisville Study			Comporison Dotobases	
	Cases	Control Group	p Value	Notionol	Birmingham
Number	15	300	—	167	106
Moternol Chorocteristics					
Age (yrs)§	21.5 ± 1.4	25.3 ± 0.3	0.009	23.0 ± 0.5	21.7 ± 0.5
% Nonwhite	53	22	0.009	35	30
% Single	60	38	0.104	47	35
% Privotely Insured	20	52	0.017	33	NA
% Primogravido	53	34	0.168	46	NA
% With Living Children	36	53	0.275	53	73
Infont Chorocteristics					
Birth Weight (kgs)§	1.9 ± 0.2	3.4 ± 0.03	<0.001	2.2 ± 0.06	NA
Gestotionol Age (wks)§	35.1 ± 1.3	39.0 ± 0.1	<0.001	35.7 ± 0.4	NA
% Cesoreon Delivery	60	24	0.004	33	NA
% Mole	67	53	0.305	53	51
% Eorly Deoth‡	27	NA	—	NA	12

§ mean ± stondord error; ‡ first 6 weeks of life; NA = not ovoiloble

the years 1966 through 1989 in Birmingham, AL.[5] Here, Chi squared with Yates' correction was used to examine proportions and the *t* statistic was calculated from the published means and standard deviations.

Results

From January 1990 through March 1993, 15 infants meeting the case definition of symptomatic congenital CMV infection (14 confirmed) were registered at the University of Louisville. The origin of these cases by maternal county of residence is shown in Fig 1. Ten of the mothers resided in Jefferson or Hardin Counties, which were also the counties with the highest number of live births. Eight infants were delivered in Jefferson County, 3 in Hardin County, and 4 in other counties; 11 were seen in the newborn period by one of the authors. From January 1, 1990, through December 31, 1992, 167 infants (155 confirmed) were registered in the national database from sites other than Louisville and Birmingham.

The upper panel of Table 2 shows demographic characteristics of mothers delivering babies with symptomatic congenital CMV infection. When compared to the control group of mothers delivering infants in Jefferson County, they were younger (mean age 21.5 *vs* 25.3 years, $p = 0.009$) and more often nonwhite (53% *vs* 22%, $p = 0.009$). Twenty percent were privately insured compared to 52% of control group mothers ($p = 0.017$); inasmuch as private insurance is a marker for mid-to-upper socioeconomic status (SES), mothers delivering symptomatic babies appear to derive from lower SES groups. Data from the national registry and the Birmingham experience are also shown in Table 2. The only statistically significant difference noted was the lower percentage of Louisville mothers with other living children (36%) compared to Birmingham (73%; $p < 0.02$).

The lower panel of Table 2 shows characteristics of infants in this study. Case infants were premature (gestational age 35.1 *vs* 39.0 weeks, $p < 0.001$) and small (birth weight 1.9 *vs* 3.4 kilograms, $p < 0.001$) compared to infants in the control group. Sixty percent were delivered by Cesarean section, compared to 24% of control infants ($p = 0.004$) and 33% of infants in the national database ($p = 0.048$). Also of note is the mortality rate of 27% in the first 6 weeks of life.

Fig 2 shows the frequency of various clinical and laboratory findings in infants from the Louisville, national, and Birmingham databases. The most common clinical signs in our series were petechiae (67%), jaundice (67%), small for gestational age (60%), hepatosplenomegaly (60%), and microcephaly (60%). When the Louisville cases were compared to the national and Birmingham databases, the only statistically significant difference was the higher incidence of jaun-

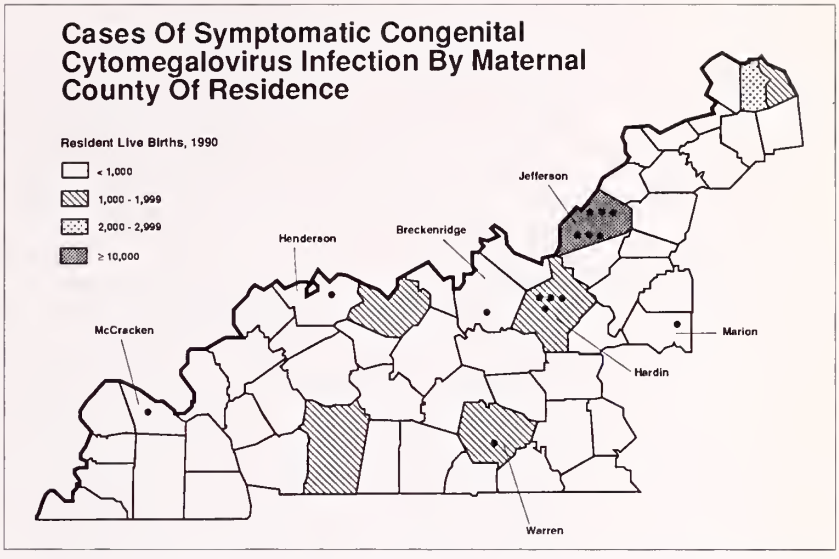


Fig 1 — Passive surveillance for symptomatic congenital cytomegalovirus infection in the Louisville area: January 1990 through March 1993. Cases are shown by dots in the mother's county of residence. Total live births per year to women residing in each county are given in the legend.

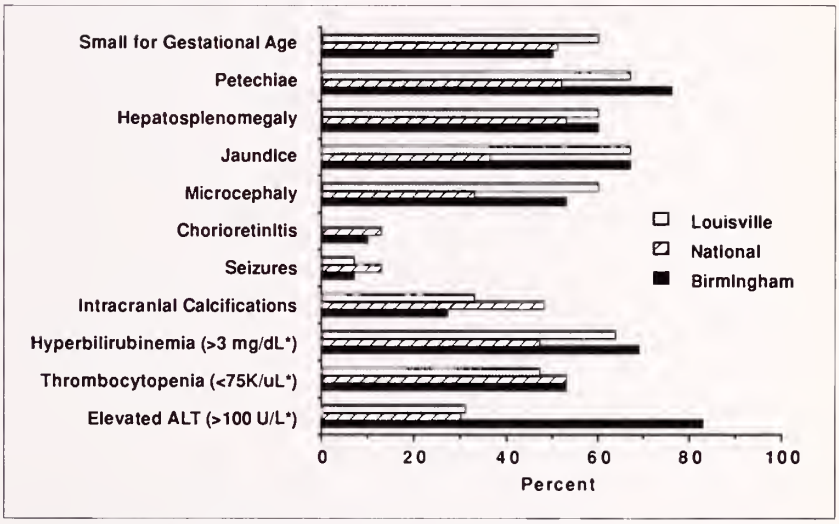


*Fig 2 — Clinical features at birth of infants with symptomatic congenital cytomegalovirus infection. Data are shown from the Louisville area since 1990 (n = 15), from a national database excluding Birmingham, Alabama, 1990-1992 (n = 167), and from Birmingham, 1966-1989 (n = 106; reference [5]). ALT = alanine aminotransferase; * = cutoff values for Birmingham data were >4 mg/dL, <50K/uL, and >80 U/L, respectively. See text for significant differences.*

dice as compared to the national experience (67% *vs* 36%, p = 0.026). Notably, though, there was no difference in the occurrence of hyperbilirubinemia. Laboratory values could not be directly compared with Birmingham since the nominal categories used were different (see Fig 2 legend).

Four patients in our series died during the neonatal period and one died shortly thereafter, for an overall infant death rate 33%. All deaths appeared to be associated with complications of prematurity or refractory manifestations of CMV infection. One patient remains critically ill at 2 months of age in the neonatal intensive care unit. We were able to obtain follow-up information on 7 of the remaining 9 patients who survived the neonatal period. Five appeared to be doing well, although the degree of scrutiny for residual abnormalities was not assessed. Two of the patients have significant sensory and developmental delays.

In order to calculate the minimal incidence of symptomatic congenital CMV disease in the Louisville area, only resident live births in Jefferson County and the 5 adjacent counties were considered. At least ten congenitally-infected babies were born over 3.25 years whose mothers resided in those counties. During the same period of time, Kentucky vital statistics estimated 44,486 live births for this area. Therefore, the minimal incidence of symptomatic congenital CMV disease is 2.25/10,000 live births. Stratifying for race, the rates are 1.16/10,000 for whites and 6.06/10,000 for nonwhites.

Discussion

Congenital CMV disease appears to be a major health problem in Kentucky. Using passive surveillance, 15 cases were identified over approximately 3 years in the referral area of the University of Louisville. For the immediate 6 county surrounding area, where case ascertainment was expected to be high, the incidence of this disease was found to be appreciable, if not striking, when stratified for race (incidence data generated here must be taken to represent minimal estimates only). For perspective, it should be noted that since 1982, only 7 cases of perinatally acquired AIDS have been reported from the entire state.[6] Although congenital CMV disease is not universally fatal, as AIDS ultimately is, many children with CMV who survive require intensive medical and social supportive services. Thus, despite public perceptions regarding the gravity of the pediatric AIDS epidemic, the actual public health burden from congenital CMV disease at the present time in Kentucky may be greater.

The most important determinant of outcome for infants with congenital CMV infection is the antibody status of the mother.[7] Whereas maternal-fetal transmission can occur when the mother is seropositive (ie, infected) prior to conception, the consequences for the fetus are mild or nonexistent. Conversely, primary infection during pregnancy (ie, infection in women who are seronegative at conception) poses the greatest risk to the fetus. Thus, the incidence of symptomatic congenital CMV disease is determined by the prevalence of susceptibility to CMV in women of childbearing age and the likelihood of acquiring the virus during pregnancy. In our study, the estimated minimal incidence of this disease in nonwhites was much higher than that in whites. However, our previous study showed that nonwhite race was associated with higher rates of immunity in women of childbearing age.[8] This would seem to point to much higher rates of CMV transmission in nonwhites; in other words, although there are fewer susceptibles in nonwhite populations, their opportunities for exposure to the virus are probably greater. Such exposures could occur sexually[9] or through close contact with children who are shedding the virus in urine or secretions.[10] Interestingly, the proportion of women with previous pregnancies and other living children was similar in cases and the comparison group, suggesting that factors other than exposures to young children were involved in virus acquisition.

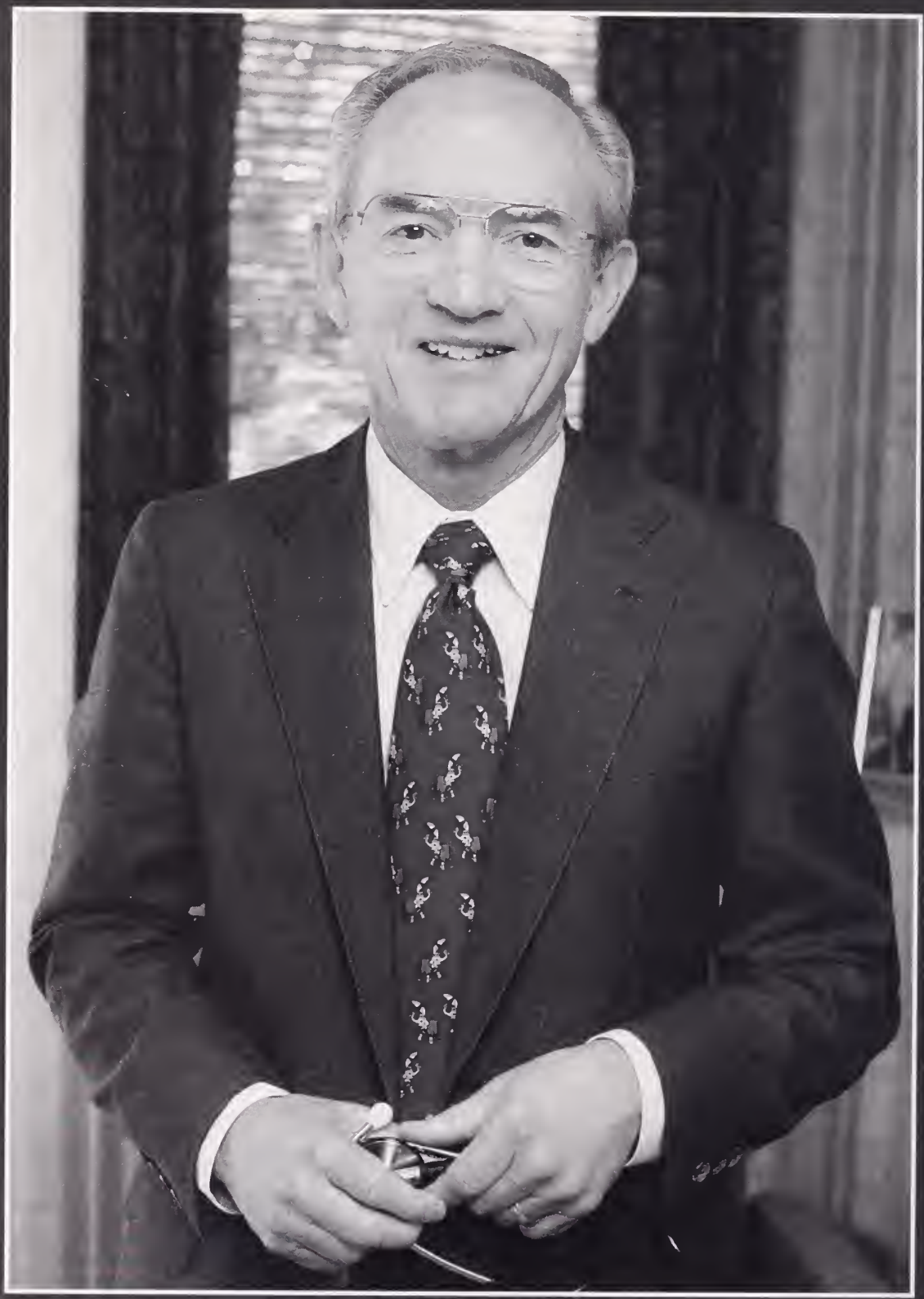
Infants in this study were severely affected, as evidenced by prematurity, low birth weight, neurological damage, and early death. While mortality data were not available from the national registry, the Louisville neonatal death rate (27%) was higher than that reported from Birmingham, although the difference was not statistically significant. Other manifestations of disease, summarized in Fig 2, were similar to national and Birmingham cases, suggesting that there are not major regional differences in disease expression.

This study establishes congenital CMV infection as a significant cause of infant morbidity and mortality in this region of Kentucky. Given the methodology employed, it is likely that only the most severely affected cases born in proximity to Louisville were ascertained. Therefore, the true disease burden is likely to be greater than that estimated here. Carefully conducted regional ac-

tive surveillance and case-control studies are needed to fully delineate the public health impact of this disease, to identify high-risk groups, and to lay the groundwork for potential interventions. Although antiviral chemotherapies for CMV have been developed, they are unlikely to benefit those infants who are profoundly affected prior to birth. Given the practical and sociobehavioral problems inherent in minimizing virus exposures during pregnancy, the most promising intervention at the present time is the development of a vaccine.[11] Prospective studies that build on the observations reported here might facilitate optimal vaccine targeting.

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Robert R. Goodin, MD KMA President 1994-95

This very accomplished physician, who has not forgotten his roots and considers his rural upbringing an asset rather than a detriment to his accomplishments, spoke forthrightly about his formative years.

"I was the second of nine children. My parents were really good, hard-working people. Dad ran a country store and we worked the farm. My Dad was a hard-charging, aggressive person, who most of all wanted to see his children educated so they could rise above his tough life-style. He could not be happy with anything less than excellence, and though there can be a down side to this, it worked for us.

"We had a little two-room school and thought we were lucky because other people we knew had a single room — 8 grades in one room. But we had 4 grades in one room. It was terrific as far as I was concerned. I did not find such a learning environment a handicap whatsoever."

This exemplary attitude and love of education led this young student from his small rural school just outside Columbia, Kentucky, to the position of a highly respected cardiologist, the senior physician of a 20-member cardiovascular group. And on September 21, 1994, Robert R. Goodin, MD, rose to the leadership of the medical community in Kentucky when he was installed as the 144th President of the Kentucky Medical Association. His Dad, now deceased, and Mom, would say, "Excellent, son."

Leadership Through Education

The importance Dr Goodin places on education permeates his conversation — about the past, present, and future. "I have given much thought to this coming year and I really hope that leadership through education will occupy my tenure. I'm convinced that physicians respond to well informed, reasoned answers to questions, and good data. There is enough good data out there for us to remain very confident, to take charge, and take something that is changing and scary and make it into an opportunity."

Dr Goodin accepts change and the threat of change as challenges, not ruin. He offers KMA the confidence needed to meet the challenges awaiting the Association and medicine in general during the year ahead. "Through facilitation of the implementation process of health system reform which we have in Kentucky, I hope to convince physicians that this is not the end of the world. This is an era of change. But the main reasons we went into medicine are all still there, despite current circumstances. We can work with managed care, we can work with health system reform, and we can still do a lot of good and be proud of our profession."

A self-professed optimist, almost to the point of Pollyanna, Dr Goodin brings a positive outlook to his leadership. "I can't help but think of what Dr Ralph Denham, who was our senior member when I left medical school and joined the cardiology group 20 years ago, said 10 years ago about DRGs. Everyone was getting upset and he said, 'You know, you guys should have been around here in the mid-60s when we had to get used to Medicare and Medicaid. We thought it was the end of practice as we knew it, that this was socialized medicine. As a matter of fact, it turned out to be something of a boon for physicians.' Now, I don't want to sound too optimistic and say there aren't downsides to what is taking place with health reform and managed care. But I sure like to think we're smart enough and our heads are held high enough as physicians to look the thing right in the teeth and say there's gotta be some good little opportunities in there and we're gonna grab them, instead of just tucking our tails, putting our heads down, and saying 'Hit me with another pie.' I just can't take that attitude, and I won't. What I'd like to emphasize this year is that we physicians are conservative, we're taking change to be automatically

Robert R. Goodin, MD

undesirable, and it's just not necessarily so."

Dealing With Reform

"Presently, what is being discussed both in the US House of Representatives and the Senate would have almost no impact in Kentucky because of what has already been enacted this year," says Dr Goodin. "Of major impact will be the increased bureaucracy and a lot of cuts in Medicare and Medicaid, resulting in less care to those patients and less physician reimbursement.

"Our response to this has to be the 16-point plan the AMA started with Health Access America in 1990, before anyone had a proposal. Necessary revisions have been made along the way, but the basic message is clear, and it should be true in Kentucky. VOICE, PLUS CHOICE, PLUS COVERAGE, EQUALS MEDICINE SUPPORT, meaning this: Physicians have to have a VOICE in what is done because only we can practice medicine, only we can direct quality of care; CHOICE has to be the patient, they must have a choice of insurance plan, choice of doctor; and third is in universal COVERAGE. I agree that's an absolute necessity. I recognize it can't be done in 5 years — it will take a lot of years."

Dr Goodin's message to all physicians who wish to achieve this goal and preserve even the slightest control of their destinies in an uncertain future is simple and urgent: Get involved now in the activities of the Kentucky Medical Association and in the political process, and stay involved. He emphasizes:

— Take advantage of every opportunity to speak with legislators.
— Work at the polls for those candidates who share our philosophies, who put patients first.
— Access the staff of the legislature, the people who write the rules and regulations of each bill, to be sure they are informed on how rules impact patients in terms of quality care.

He has often been surprised by the depth of knowledge he encounters among physicians on issues. "This year is probably a turning point in Kentucky for physician involvement and effectiveness in the political process. Many legislators related that they *are* getting letters, they *are* getting phone calls. I suspect that 95% of physicians feel as I do — I could be happy if I never spent another day around the political arena or in Frankfort. But it's what we must do. And many physicians now understand that much of what concerns us can only be handled through our communication with politicians. We have tremendous lobbyists within KMA. Between Don Chasteen, Bill Doll, John Cooper, and Dave Carby, you just can't do a better job. But we physicians must also do our part."

Introduction to Medical Politics

As for the political arena, Dr Goodin was stirred into involvement in 1963 when he was elected President of his senior class at the University of Louisville School of Medicine. "My involvement slowly evolved. By 1977, I was a member of the Jefferson County Medical Society Board of Governors, then JCMS President in 1980-81. Out of that evolved KMA service as an AMA Alternate Delegate, Delegate, and membership on several committees. Once you get in, you can't get out."

As for his road to the presidency, it wasn't planned. "I'm a Type A person, I like to see things move and get going. I almost lead by default, because I'd be just as happy on the sidelines watching someone else do the same things. But on the other hand, I get impatient. If I have the experience and background information from moving along through these different positions, then I think — someone has to do it, so I will."

KMA and AMA Membership

For any organization to be strong and vital and to grow, its members must share three qualities or characteristics: loyalty, cooperativeness, and generative commitment. If physicians espouse a medical career for the bright young students of the next generation, they must establish, guide, and nurture the reasons for that espousal. Dr Goodin states it this way when considering the strength and control of the profession. "Every physician absolutely has an obligation to be a member of organized medicine, even if they do not decide to take a leadership role. It should be an obligation from the day you enter medical school."

Concerns that should unite physicians are far more important, for patients as well as physicians, than the concerns that may divide them. Unified medicine is a must, and Dr Goodin succinctly states many reasons. "Less than 45% of KMA physicians belong to AMA. Can you imagine how powerful we would be if even 80% of the physicians in the United States were members of AMA? A real problem is when an AMA lobbyist goes to Washington — he is placed in the precarious position of hearing, 'Well, you represent less than half the doctors in this country, why should we listen to you?'

"I'm convinced that the annual dues are a good value if you look at nothing more than the educational side of AMA — all the credentialing and accreditation they do for our medical schools, residency, and CME; setting ethical standards for all of us; scientific assessments of what's good, what's bad; and public health information. It's a bargain, to say nothing of their lobbying and activities at the legislative end. To me,



Dr Robert R. Goodin's family proudly shared in his inauguration as the Kentucky Medical Association's 144th President. Pictured with him L to R — son Bobby, wife Carol, and daughters Kara and Jodi.

if we physicians can't look at it from that standpoint, then we really aren't being very loyal to a profession that deserves more."

Dr Goodin serves on the Continuing Medical Education Advisory Committee at AMA, and with KMA's endorsement will be running for office on the Council on Medical Education at AMA next summer. His enthusiasm is palpable as he speaks of his AMA involvement. "Dr Joe Painter, immediate past president of AMA, has put together a group of physicians and executives from throughout the country to study the AMA in its structure, its makeup, and to make it a better organization — even if it means totally tearing it down and building a new one. I'm excited about this, because it's an open process, not just a formality."

Economic Entities Committee

Dr Goodin is KMA's guru on managed care, but with his usual humble attitude of, "let's get the job done, never mind who gets the credit," he downplays his role in this newly established KMA committee. "A year ago I didn't know what managed care was, and now I'm a so-called expert. With the leadership of Bill Applegate and Dave Carby, though, we have been able to catch up with the information side. Managed care in California, Minnesota, Florida, and somewhat in New York, has been growing at a rapid pace, and it's beginning to grow more in Kentucky. It's our goal to simply become an educational service for our physicians. They will have a source they can call for information direct, and also gain further knowledge through consultants accessible through KMA."

Currently, the threat of health system reform linked with the corporate rush to managed care is already resulting in an unprecedented push to integrate physicians into larger groups and a variety of health systems. Of major concern to Dr Goodin and to KMA is that many physicians, especially primary physicians, are leaning toward selling their practices. He affirms, "We simply must educate them on the amount of power and control they can have in managed care, but only if they get organized as physician groups. That is the key message we hope to spread around the state.

"The presentations we've made in various locations have been very enlightening. In Prestonsburg, for instance, out of a group of 40 physicians, not one had a patient in managed care. On the other hand, in my own practice, and that of most physicians in Louisville, Lexington, and Northern Kentucky, of the non-Medicare patients, I would say 70% have some managed care agreement or contract. That is the reason we decided we couldn't do a single statewide physician organization but instead could facilitate regional organizations.

"Physicians should find this program to be a real benefit to being a Kentucky Medical Association member, and I think we should

Robert R. Goodin, MD

clearly see a sharp increase in our membership. Connecticut and South Carolina have gone with statewide organizations, and they're experiencing healthy growths in membership."

The Profession

The influence of family physicians in his hometown of Columbia led Dr Goodin to medicine. "We lived out in the country, but there were three family physicians in town — Drs Salato, Nell, and Loy. These gentlemen stood out in the community as the most educated. They were kind, compassionate, and had the respect of the community. They were always called on — on everything from school matters to family matters.

"Another influence came from a tremendous person, John Burr, my baseball coach at Adair County High School. Despite my great enthusiasm and interest in playing college and hopefully more advanced baseball, he suggested that my academic route was probably going to be more productive than a baseball career.

"I also have my medical heroes. Dr Carl Moore, chairman of medicine at Washington University in St. Louis, was an incredible, ultimate physician model. Also Dr Willis Hurst and Dr Bruce Logue at Emory, where I did my cardiology fellowship. And here in Louisville, Dr Ralph Denham, who I mentioned earlier, and Dr Charles Smith. Both are just role models for anyone who wants to be the ultimate physician. There is no way I can reach them, but it's nice to see them around to keep reminding me that I can do better."

Dr Goodin emphasizes to young people that Medicine is by far the single best profession there is. "To me being a physician is really an honor and a privilege. It offers the ultimate challenge — to do the best you can in a setting where you know you can never be perfect. That's a heavy burden at times, but that's the ultimate essence of being a physician.

"One message I really push with young students and residents is to be very careful in choosing a specialty. When you spend, as in our case, a good 70-75 hours a week in a profession, it better not be for economic reasons, but because you enjoy it.

"I chose cardiology because of the things you can do at bedside — cardiology is very much a hands-on specialty. My decision was made long before the technology explosion and long before it was a lucrative specialty. It was simply an ordinary specialty." But it has not been an ordinary endeavor for Dr Goodin. "We certainly don't take credit for making the patients well, but we facilitate the healing process, and to see the turnaround in not only the patient but in the family is a kind of reward that you can't imagine. And to receive thank you notes and letters from those families, and even the families of patients who did not survive — there's no dollar value on that. It's amazing."

The Personal Side

A self-professed Type A personality from birth, "which means I have a high energy level," Dr Goodin's life is filled with a whirlpool of activity that could intimidate the neophyte, but it doesn't faze this President. He maintains a healthy stress level by practicing what he preaches. "We type A's just simply do not thrive on inefficiency, but the best stress controller and reliever the world has ever known is exercise." An excellent golfer, Dr Goodin also enjoys running, the Nordic Track, and downhill skiing. "My wife Carol and I really enjoy skiing and traveling when time permits. Carol's background is in nursing, and she is a tremendous volunteer, currently serving on the Kentucky Health Education Center Committee and also on the board of The Healing Place. I'm really proud of her because she is very active with both the local and state Alliance, and is a past president of the Jefferson County Auxiliary. Of our three children, the oldest, Jodi, is in graduate school in psychology at Xavier University. Bobby is a third year medical student at the University of Louisville, and our youngest, Kara, is a second year pre-med student at Washington University in St. Louis.

"Our family is active in St. John Lutheran Church, and another involvement that is important to me is my service on the board of Lindsey Wilson College, a small Methodist College back in Columbia. It was a junior college when I went there, but is now a 4-year school. They serve a unique purpose for rural students like me who might be reluctant to go to the big university."

The Presidency

"It's easy to start something like this with the idea that you can make dramatic, big-time changes. But you very quickly learn from those who've been there before and from previous experience that you must not get your goals too high unless you are willing to accept less. But I believe that I have a significant goal that is reachable. After my year as President, if we can say that a significant percentage of physicians have stopped, just for a little while, to reflect on our profession, and through that process renewed their sense of pride in medicine, a pride in our profession, then I'll be happy."

When asked how he would like to be remembered as President of the Kentucky Medical Association, Dr Goodin smiled and answered without hesitation, "As a caring and compassionate physician who tried to promote the profession in this role."

— Sue Tharp
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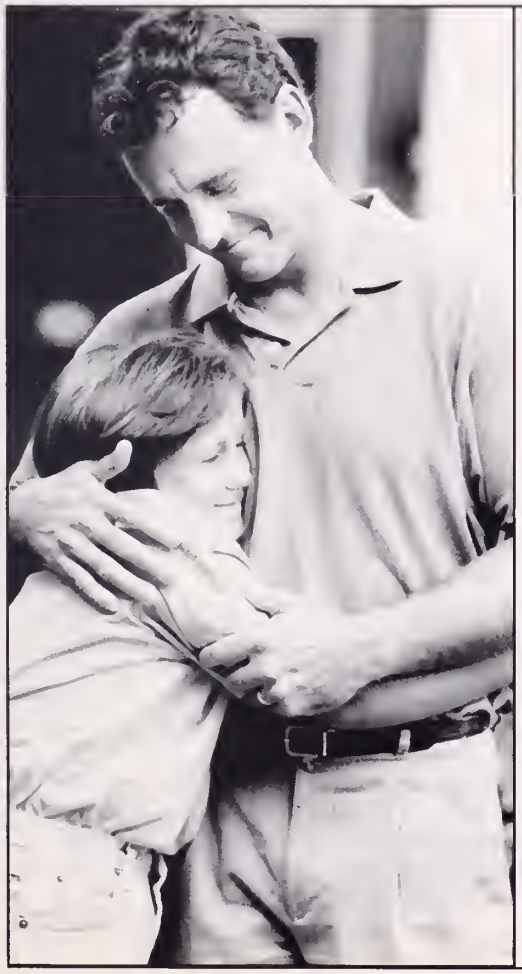
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AIR FORCE

Now Count Your Men, Hitler

It has been several years now. We were sitting on the Belgium-Germany border a few hundred yards from the "dragon-teeth" of the famed Siegfried line. The German Wehrmacht (if you will pardon the redundancy) had "shot it's bolt" in the Ardennes offensive. Their army was in complete disarray and more particularly shortages abounded. The Luftwaffe was nonexistent. Tanks lost were irreplaceable. Petrol was scarce. Rations were poor. Ammunition, both small bore and artillery, was limited, and any horsepower produced was truly horse power.

On the other hand, the allies had a largess of men and material that was overflowing. The Air Force had complete control of the air. A tank lost was replaced the next day. We had gasoline "up our gazoo," what with P.L.U.T.O. (petroleum line under the ocean) that ran from the Isle of Wright to Cherbourg and later to Antwerp pumping out hundreds of thousands of gallons of gasoline per day.

One hot meal made it to the front each day and ammunitions of all caliber were unlimited. It is to this abundance of artillery shells that I write.

A directory came down from corp or perhaps division to fire on designated targets and also targets of opportunity. What with the plethora of ammunition and eager troops, the 105s and 155s were active night and day with harassing fire.

So I'm sitting there in my foxhole eating a breakfast K ration for supper, and a nearby battery caught my attention. After each salvo was fired, the artillerymen would run in front of their cannons, form up in a smart line and holler out in unison, "Now count your men, Hitler."

"Gee! Beating the Wehrmacht was a piece of cake compared to this. And they were the enemy."

This well worn vignette came back to me a few months ago. I was reading of the gradual decline in support of President Clinton's universal health bill. I found myself thinking, with a good bit of glee I must admit, "Now count your support, Clinton." Our esteemed President was receiving shot and shell from the right and the left. The Republicans are offering their own proposal for health care change. The Democrats, even the stalwart ones, were jumping ship and disavowing the President's plan. Insurance companies, major industrial leaders, small businessmen, and now even the general public (according to a NBC poll) is not supporting changes in health care.

By the time you read these words, health care legislation will either still be hotly debated or else passed in some form. Even this was unthinkable 10 years ago.

Is the change necessary and will the change be good? Who will benefit? The patient? The doctor? The hospital? Large business? Small business? The self employed? The medical schools? The pharmaceuticals? In the final shake out, I feel all of the above will be hurt or at least not benefited.

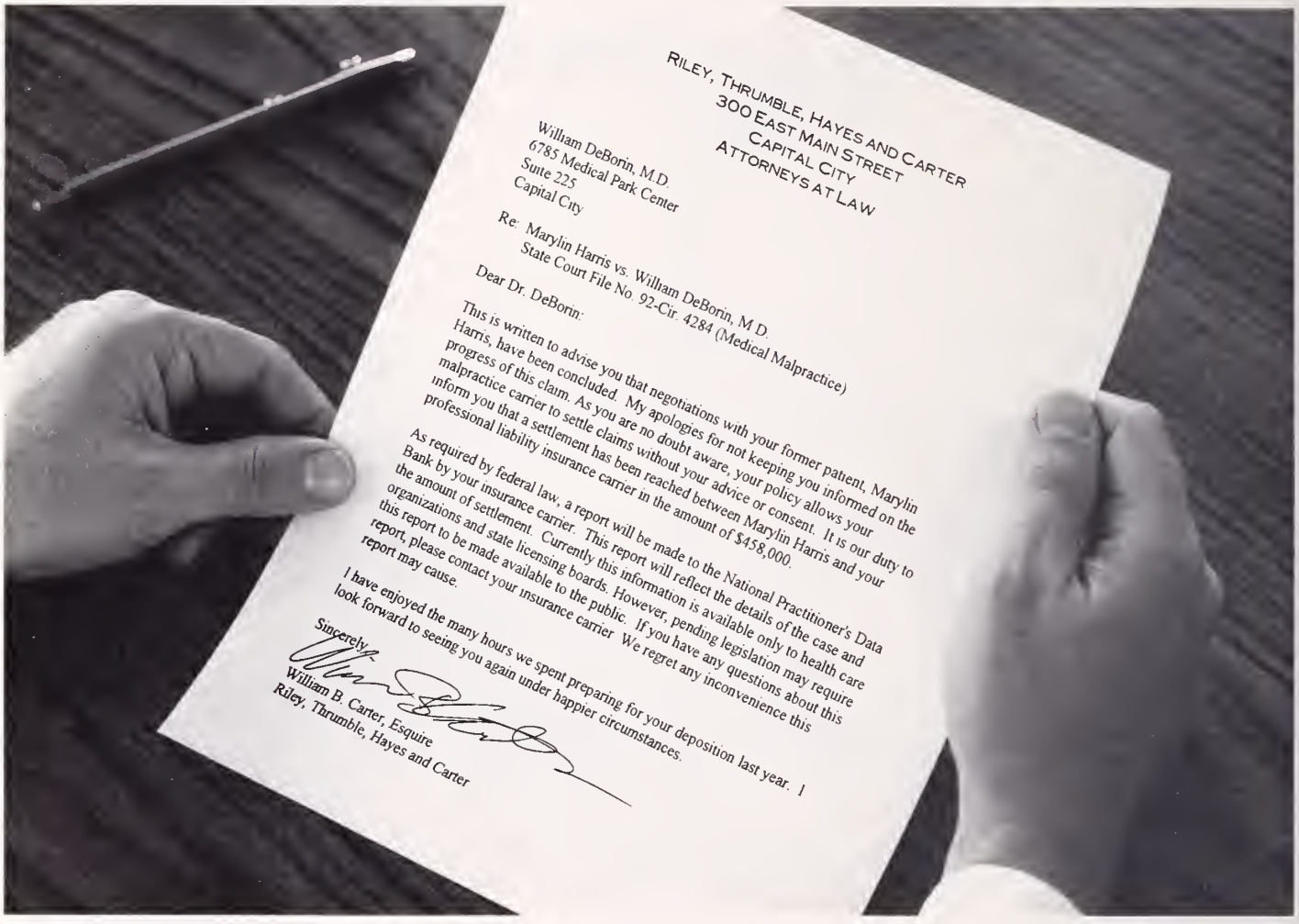
These "great" social changes that have been passed as laws over the past many decades have never lived up to their promises or hype. The architects who crafted these changes are never around years later to see the havoc and expense their programs have wrought. There seems never to be any accountability.

So where are we here? The winds of change will not be as draconian as the Clinton plan, but the practice of medicine will become more difficult and different from what we know. At best we can hope changes will be phased in slowly, so mistakes made can be corrected. Whatever happens, the cost in dollars will be staggering, and to rectify that, more constraints will be implemented. Yet we may still dodge the bullet.

Gee! Beating the Wehrmacht was a piece of cake compared to this. And they were the enemy.

Milton F. Miller, MD

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Marla Vieillard

Leadership Confluence I The Drake, Chicago October 2-4, 1994

Alliance/Auxiliary members attending Confluence whether it be in the fall or winter will be in for a positive experience they might not expect. County presidents-elect and most of the Kentucky Medical Association Alliance's board members will attend one or both of these leadership training and information programs given by the American Medical Association Alliance. I have been amazed at the quality of the speakers, program content, information materials available, and the overall organization of these Confluences.

Sherry Strebel, a past AMAA president and current AMPAC board member, and Nancy Kessel, a member of the West Virginia House of Delegates, will present "Playing the Political Game . . . and Predicting the Future." This session will teach some things one can do in the late stages of this election cycle, and how to be involved in electing the candidates who carry the banner for quality reform supported by organized medicine.

State presidents and presidents-elect will follow the state track which includes a session on membership, national updates, and break-out sessions. The county presidents will follow the county track which begins and ends with roundtable discussions on national priorities and county concerns, with an in-depth session on membership issues.

The educational experiences garnered from this meeting surpass classes taught at college. We may not have been exposed to these topics before or had a need to be prepared. As a county or state officer at one time we will all be giving speeches or writing speeches and articles for publication. The Alliance brings in experts to tell us how to make the most of our speaking opportunities, how to bring out the traits in leaders to keep the momentum going to reach county and state goals. Everyone's time is limited because most of us are over committed. We are trying to be SUPERMOM, SUPERDAD, or the SUPERPROFESSIONAL. The Alliance brings in Michael Steinberg to talk on Tackling Time Traumas. There will be sessions on Adolescent Violence; Growing Healthy; Saying No in the 90s When You Said Yes in the 60s; Media Effects on Children; A Legislative Update by the chairman of Legislative Affairs; Parliamentary Procedure, a new look at an old topic; and gaining community recognition for community efforts.

Medical Alliance Month is March 1995. We will find out how to use the media for our message on where our story fits into the local news agenda. This will round out the break-out sessions Tuesday, October 4.

As a potential or future Confluence participant, don't be intimidated by the full sessions. The information is only part of what you will come home with. You will meet many Alliance/Auxiliary members from all over as well as many of the National leaders. All are great supporters of the Alliance and their medical spouses. You will be energized by their enthusiasm and have recharged your batteries to be an effective county or state leader. The leadership training received from Confluences will be invaluable in your future challenges.

GO, LEARN, PARTICIPATE, and you may wish you could go each time. I consider Confluence a golden opportunity, and I feel fortunate not to have missed this opportunity.

Marla Vieillard
KMAA President-Elect

August Board Meeting

The KMA Board of Trustees held its fifth meeting of the Association year on August 10-11, 1994, at the Holiday Inn Hurstbourne in Louisville. Reports were given by the President; Secretary-Treasurer; President, KMA Alliance; Senior Delegate to AMA; Vice Chairman, Kentucky Medical Insurance Company; and the Commissioner for Health Services. In addition, the Board heard presentations from the Dean of the University of Louisville School of Medicine, and from a representative of the Board of Medical Licensure.

The Secretary of the Cabinet for Human Resources, Masten Childers, addressed the Board and announced his intention to foster improved communications with Kentucky physicians. The Board authorized the Executive Committee to form a committee to meet with the Cabinet to address matters affecting the profession.

An update was given on the status of health care reform following adoption of HB 250 by the 1994 session of the Kentucky General Assembly. The Board reaffirmed its support of the use of the Legal Trust Fund to continue its challenge to the constitutionality of HB 1, the provider tax, to fund Medicaid.

In other action, the Board approved a Resolution to be introduced into the 1994 House of Delegates to raise the $10 voluntary assessment for the Legal Trust Fund to $25, effective with the 1995 dues billing; selected physicians to serve on Governor-appointed councils; and reappointed the KEMPAC Board of Directors.

The Board reviewed its Ad Hoc Committee reports, as well as each final committee report to be submitted to the 1994 House of Delegates. Several Board members who chair committees gave auxiliary reports, including the Chairs of the Committees on National and State Legislative Activities, Public Education, Medical Insurance and Prepayment Plans, and the Physician Organization Study Committee.

A listing of actions taken to implement the directives of the 1993 House of Delegates was distributed, and it was noted that the same information would be sent to every Delegate as an addendum to the 1994 Board Chair's Report.

The next meeting of the Board was scheduled for Sunday, September 18, 1994, during the Annual Meeting.

KMA

To Our Exhibitors
and
Special Contributors:

For Continued Support and
Helping to Make the
KMA 144th Annual Meeting
a Success—

THANK YOU!

PEOPLE

Joseph B. Brill, MD, has been elected to fellowship in the American Psychiatric Association.

Nettie Graham King, MD, a clinical professor in the Department of Radiology at U of L's School of Medicine, has been selected by the University of Louisville as a 1994 Alumni Fellow. Fellows are chosen by their peers as the very best U of L representatives.

UPDATES

U of L Health Care Teams Provide Rural Care

Four interdisciplinary teams of health care students have spent some time this summer conducting health checkups on some of Kentucky's neediest and most rural citizens.

The teams, made up of a medical student, a nursing student, a dental student, a social work student, and a faculty member from U of L's Health Sciences Center, held clinics in Fulton, Dawson Springs, and Brownsville.

"We work closely with the regional Area Health Education Centers (AHECs), who make sure we see the people who really need us," said **Richard E. Aud, MD,** an assistant professor of family and community medicine at the U of L School of Medicine.

Team members take an extensive health history and administer a complete physical exam including some elementary lab work. Once that is done, the team members evaluate the patient's health problems and potential risks. They refer any medical problems back to the AHEC, which sees to it that the patient gets follow-up care from local health professionals.

This is the second year for the Kentucky Interdisciplinary Screening Project, and Dr Aud characterizes it as a "raving success."

"We find an overwhelming number of children's dental problems. We refer them to local dentists who volunteer their time. We've also found some eyesight problems that the Kentucky Lions Eye Institute helps us with. Last year we even found initial signs of a possible gastrointestinal cancer that was caught and treated early.

"A lot of what we do is educational," Dr Aud added, "letting people know what they could do to improve their overall health."

For the team members there are professional perks as well.

"We were surprised," said Dr Aud, "at how unaware health care professionals were about what other professionals do. By working together, the team members develop an appreciation for each other's talents and abilities."

Cancer Surgeon Visits Chilean Colleagues

John S. Spratt, Jr, MD, U of L professor of surgery, was recently invited by the American Cancer Society and the National Cancer Institute to visit and lecture in Chile. The groups jointly operate an International Professorship program which sends US college professors "around the face of the earth," Dr Spratt said.

Chilean surgeons familiar with his work had requested that he address the 38th Congress on Cancer sponsored by the Chilean chapter of the American College of Surgeons.

His weeklong visit included talks to several hospital staffs, sessions of ward rounds, and numerous consultations concerning cancer cases — in addition to his full schedule of lectures.

Dr Spratt's wide-ranging cancer research meant wide-ranging discussions as well. "They wanted to hear about my current work on breast cancer, on colon cancer, skin cancer and cancer of the pancreas, as well as the statistical studies on the rate of growth of human cancers."

Among his most recent research work, for example, is a study examining the relationship between breast cancer prognosis and the time during a woman's menstrual cycle when the surgery is performed. The timing of the surgery, Dr Spratt found, is indeed a significant factor. Researchers now are encouraging the National Cancer Institute to conduct an expanded study to see if the relationship stands up to a larger number of test subjects.

Dr Spratt encouraged his South American counterparts to capitalize on their growing expertise by participating in some of the clinical trials fostered by the National Cancer Institute.

Reportable Disease Regulation Amended

At its regular monthly meeting on August 17, the Interim Health and Welfare Committee amended state regulation 902 KAR 2:020 on reportable diseases to include *Escherichia coli* 0157-H7 on the list of diseases that physicians should report to the local health department or the Department for Health Services within 24 hours of diagnosis. All physicians should make note of this addition to the list of mandatory reportable diseases.

Administrative Regulation Process Begins

KMA officers and staff continue their work in Frankfort by monitoring, and

where appropriate, testifying on administrative regulations resulting from House Bill 250 (Health System Reform) and various other bills that affect Kentucky physicians.

KMA officers and staff recently presented testimony on proposed regulations dealing with Medicaid fraud and abuse (907 KAR 1:670) and various workers' compensation regulations pertaining to fee schedules, medical records, and depositions. Additionally, the Kentucky Board of Respiratory Care recently amended proposed regulations defining the scope of practice for respiratory care practitioners in response to concerns presented by KMA.

Over the coming months, Frankfort will continue to be a flurry of activity as the many regulations required by House Bill 250 proceed through the regulatory process. KMA officers and staff will remain vigilant in their efforts to monitor those regulations which affect Kentucky physicians and keep the membership informed regarding any changes.

Kentucky Health Fraud Conference

Kentucky physicians are invited to a program on "Health and Nutrition Fraud" on November 18, 1994, in Louisville at the Humana Building on 5th and Main, sponsored by the Attorney General's Health Fraud Task Force.

Speakers include Victor Herbert, JD, MD; Mr Mitch Zeller, FDA, Washington; Mr Chris Gorman, Kentucky Attorney General; **James Sublett, MD; Ardis D. Hoven, MD,** Immediate Past President of KMA; and James F. Drummond, DDS.

Registration begins at 8:30 am with the program scheduled from 9:15 am — 4:00 pm. The registration fee is $35.00 for health care professionals, $40.00 for nurses. The fee for registration after November 9th will be $45.00. For more information, call Lori Farris at 502/573-2200, or Nancy Tullis at 502/454-5174.

AMA Physicians of Tomorrow

The KMA Public Education Committee has endorsed AMA's "The Physicians of Tomorrow Mentoring Program." The program, developed by the AMA Advisory Panel on Women Physician Issues in cooperation with the Girl Scouts of the USA, will link medical societies with local girl scout councils/troops. The hands-on project is for cadet and senior girl scouts (age 14-17) and allows them to explore interests in medicine by working with a woman physician mentor. The "Physicians of Tomorrow Mentoring Program" reaches out to young women at a crucial age when they are making decisions and choosing paths that will profoundly affect the rest of their lives. We encourage each local medical society to bring this program to the attention of its women physicians. Further information may be obtained by calling Phyllis Kopriva, Director of AMA Women in Medicine Services, at 312/464-4392.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Barren

M. Todd Marion, MD — S
715 Country Club Est, Glasgow 42141
1989, U of Kentucky

Boyd

Johanna M. Korzep, MD — EM
1604 Lexington Ave, Ashland 41101
1990, U of Tennessee

Bell

Edward W. Leone, MD — AN
9 Ennismore Dr, Middlesboro 40965
1988, UMDNJ

Teresa L. Otto, MD — AN
9 Ennismore Dr, Middlesboro 40965
1988, U of Washington

Calloway

Randal K. Hughes, MD — OPH
300 S 8th St, Murray 42071
1990, Indiana U

Fulton

Louis L. Seng, MD — IM
1000 Dogwood Ln, Fulton 42041
1987, U of Louisville

Greenup

Michael W. Strange, MD — IM
12470 US 60, Ashland 41102
1976, U of Oklahoma

Hardin

Roy M. Blackburn, MD — PMR
134 Heartland Dr, Elizabethtown 42701
1987, American U of Caribbean

Harrison

Campbell K. Schulstad, MD — S
PO Box 578, Cynthiana 41031
1981, Memorial U of Newfoundland

Jefferson

Mark A. Kirkpatrick, MD — IM
10701 Hidden Creek Ln, Louisville 40291
1987, U of Louisville

Solly S. Mizrahi, MD — S
2603 Broadmeade Rd, Louisville 40205
1977, Hebrew U.

Bruce A. Runyon, MD — IM
7203 Wyndefair Ct, Prospect 40059
1976, U of Iowa

Stephen G. Wagner, MD — C
2568 Cherosen Rd, Louisville 40205
1969, U of Rochester

Maurine A. Waterhouse, MD — PS
4001 Kresge Way #320, Louisville 40207
1986, U of Missouri, Columbia

Leslie

Karen Y. Baucom, MD — OBG
Mary Breckinridge Hosp, Hyden 41749
1975, U of Missouri, Kansas City

Madison

Elliott M. Grau, MD — IM
209 Stonewall Ct, Richmond 40475
1964, NY Medical College

Paul L. Hester, MD — FP
120 Circle Dr, Berea 40403
1992, U of Kentucky

McCracken

D'Arcy A. Honeycutt, MD — PS
P O Box 7329, Paducah 42002
1985, U of Texas

Ohio

Eric A. Weisman, MD — N
1211 Main St, Hartford 42347
1985, St. George's U

Pulaski

Mohammed A. Farooqui, MD — AN
607 Woodview Dr, Somerset 42501
1982, Gandhi Medical School

Warren

Kenneth K. Bartholomew, MD — R
250 Park St, Bowling Green 42102
1969, U of Cincinnati

Mark E. Bigler, MD — U
1636 Ewing Ford Rd, Bowling Green 42103
1989, Vanderbilt

Allan H. Pribble, MD — C
201 Park St, Bowling Green 42102
1965, Washington U

In-Training

Jefferson

Peter W. Coffman, MD — P
Stephanie C. Miller, MD — PD
Mark F. Pinsky, DO — FP
Perry J. Roy, MD — IM

DEATHS

William J. Sandman, Jr, MD
Louisville
1923-1994

William J. Sandman, Jr, MD, a retired surgeon, died July 4, 1994. A 1954 graduate of the University of Louisville School of Medicine, Dr Sandman was a life member of KMA.

John A. McKay, MD
Philpot
1928-1994

John A. McKay, MD, a retired orthopedic surgeon, died July 9, 1994. Dr McKay was a 1959 graduate of the University of Louisville School of Medicine and a life member of KMA.

Jose M. Palacio, MD
Louisville
1914-1994

Jose M. Palacio, MD, a retired psychiatrist, died July 31, 1994. Dr Palacio graduated from the University of Havana School of Medicine, Cuba, in 1945 and was a life member of KMA.

Wendell V. Lyon, MD
Ashland
1918-1994

Wendell V. Lyon, MD, a retired surgeon, died August 5, 1994. A 1943 graduate of the University of Louisville School of Medicine, Dr Lyon was a life member of KMA.

James M. Keightley, Jr, MD
Lexington
1946-1994

James M. Keightley, Jr, MD, an emergency medicine physician, died August 30, 1994. Dr Keightley graduated from Vanderbilt University School of Medicine in 1972 and was an active member of KMA.

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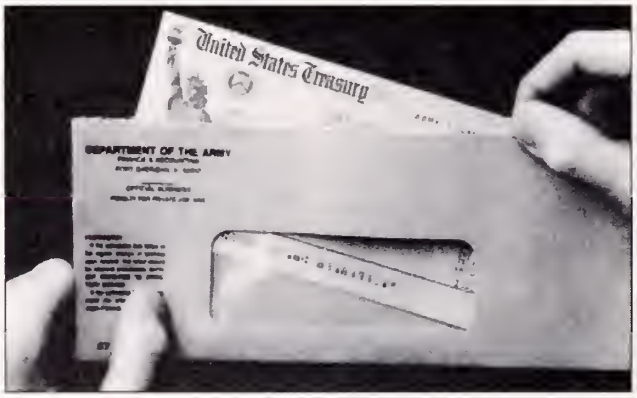
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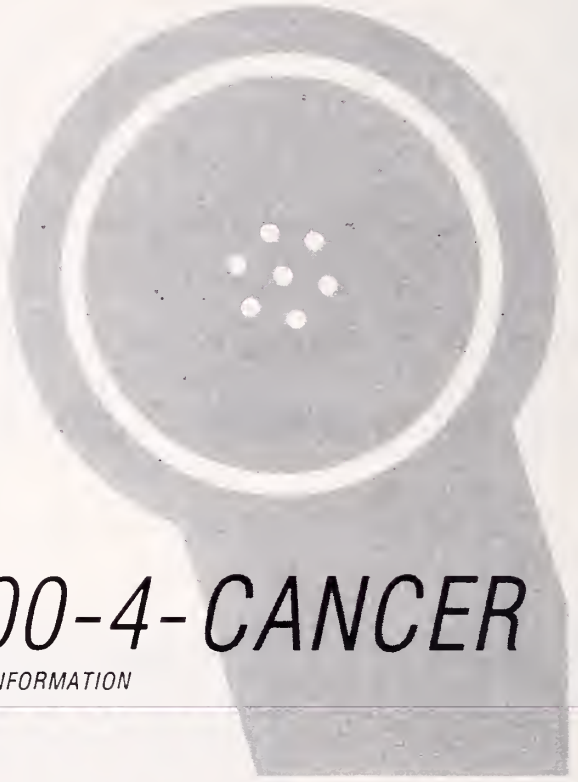
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2-6 — 88th Annual Scientific Assembly of the Southern Medical Association, Orlando, FL. Contact: Annual Meeting Registration Hotline, 800/423-4992 or FAX, 205/942-0642.

15 — Laser Assisted Uvulo-Palatoplasty — A New Treatment for Snoring, The Village at Vanderbilt, Nashville, TN. Sponsored by Vanderbilt University Medical Center. Contact: Wendy Prostick, 615/322-4030.

DECEMBER

2-3 — 20th Annual High Risk Obstetrics/Gynecology Seminar. Contact: Marilyn J. D'Asaro, Program Coordinator, Vanderbilt C.M.E. Division, 615/322-4030.

1995

JANUARY

28-February 4 — Eighth Annual Diagnostic Radiology/Medical Imaging. Contact: Marilyn J. D'Asaro, Program Coordinator, Vanderbilt C.M.E. Division, 615/322-4030.

FEBRUARY

5-8 — The Southeastern Surgical Congress, New Orleans, LA. Contact: R. Phillip Burns, MD, Suite 410N, 1776 Peachtree St, Atlanta, GA 30309.

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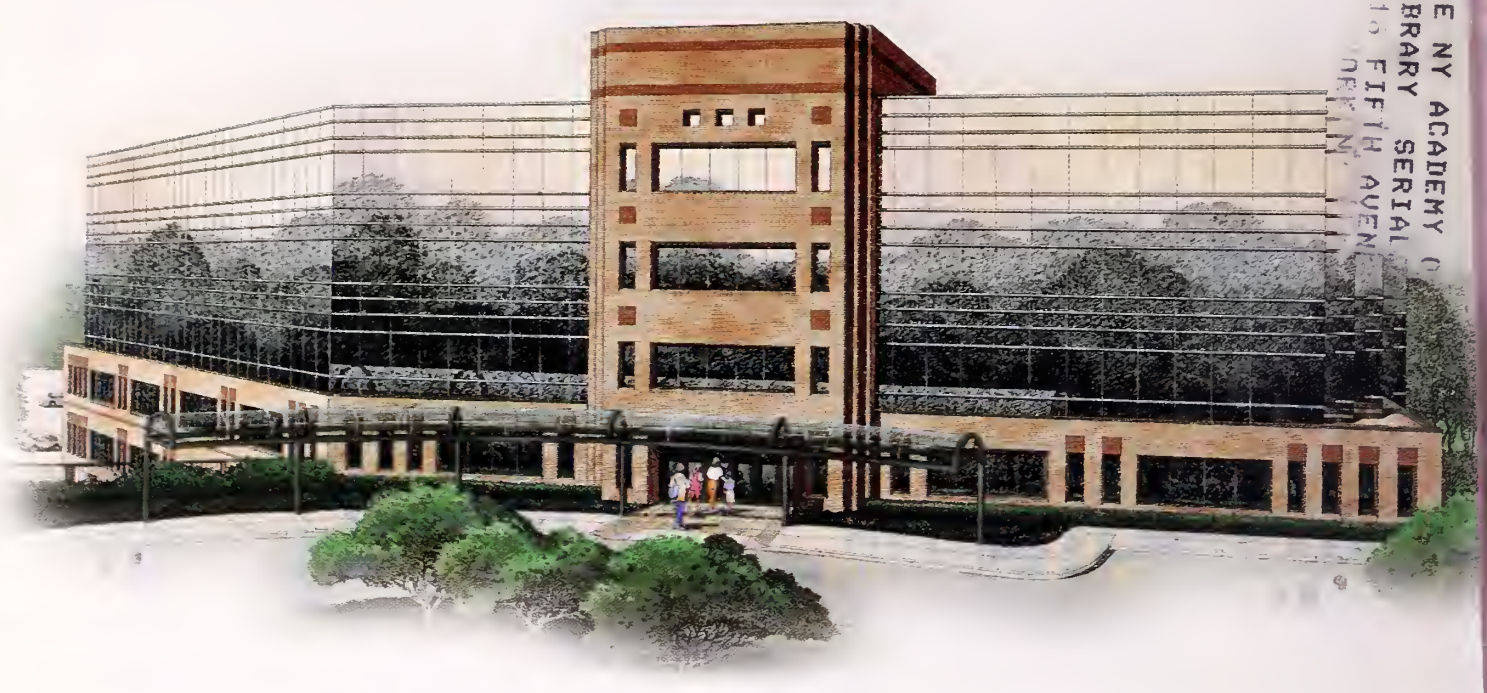
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NEWBORN HEARING SCREENING

NOVEMBER 1994
VOLUME 92, NUMBER 11

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COVER: Newborn heoring screening in Kentucky is the topic of this month's cover story. See page 444. Illustrotion by Lee Wade.

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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Second-class postage paid at Louisville, KY and additional offices. Yearly subscription rates: $25 domestic; $30 foreign. Single issues $3 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association*, 301 N Hurstbourne Pkwy, Suite 200, Louisville, KY 40222-8512. EDITORIAL AND ADVERTISING: Telephone 502/426-6200.

Listed in Index Medicus. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

National advertising representative: State Medical Journal Advertising Bureau, Inc, 11437 W 106th St, Overland Park, KS 66214, phone 800/788-2360.

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Printed by the Ovid Bell Press, Inc, Fulton, Missouri 65251.

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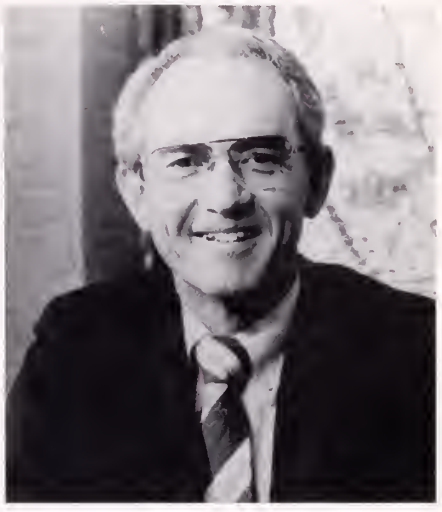
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Practice Parameters — Boon or Bane?



Robert R. Goodin, MD

House bill 250 passed by the Kentucky General Assembly in April 1994, states that the Kentucky Health Policy Board shall develop, update, and recommend implementation of parameters for clinical practice. The stated purpose of these parameters is to assess and improve the quality of health care. **What are practice parameters? Who develops them? Are they effective? Are they "cookbook medicine"?** It behooves us physicians to know more about practice parameters, or alternately called practice guidelines.

The concept of practice parameters is first referred to by work done at the Massachusetts General Hospital in 1925 by Dr Ernest Codman, a surgeon, as he tried to establish a means to measure surgical outcomes. The American Academy of Pediatrics developed guidelines for immunization in 1940. Dr John Wennberg at Dartmouth pointed out the marked variation in practice patterns in 1970 by publishing the marked differences in frequency of tonsillectomy between Boston and New Haven with a range from *13 per 10,000 residents to 151 per 10,000 residents.* By informing physicians and establishing guidelines, the 151 rapidly declined. Similar results were shown in 1984 following publication of practice parameters by The American College of Cardiology detailing the indications for permanent pacemaker implantation. In 1 year the frequency of implants fell by 28% while quality of care was not compromised, and likely was even improved. It is clear that great variations do occur in our practice patterns, and although considerable variation is inevitable and justified, the variation today is excessive.

Is it possible then to establish practice parameters that can *reduce variability, increase quality, and at the same time allow proper physician judgment in the management of complex cases?* I believe this is in fact possible. The AMA does have established policies and attributes regarding practice parameters. The AMA does approve the use of appropriately developed practice parameters for the following uses:

- Quality assessment
- Appropriate utilization of services
- Payment decisions
- Education of physicians
- Legal defense in liability cases
- **But not** for medical licensure actions

The AMA has published attributes by which parameters can be evaluated for appropriateness. The attributes require major physician input, reliable methodology, comprehensiveness and specificity, current scientific basis, and wide physician dissemination.

There are presently more than 1600 practice parameters published in the AMA directory of practice parameters. The vast majority are presented by 70 different specialty societies, and most are not of sufficient quality to be widely used. The AMA's practice parameters partnership (16 specialty societies, AHCPR, and JCAHO) is currently evaluating these parameters and publishing those that meet AMA attributes. There are two major approaches to parameter development. The AMA approach consists of in-depth literature research and medical expert consensus opinion. The Agency for Health Care Policy and Research (AHCPR) is a federal public health agency charged with quality of care research and practice parameter development. Their approach has been to go more deeply into the research of outcomes, but their approach has proven very time consuming and expensive, with an average time of development of *6 or more months* and an average cost of *$500,000 per parameter.* The great majority of practice parameters in use

"Is it possible then to establish practice parameters that can reduce variability, increase quality, and at the same time allow proper physician judgment in the management of complex cases?"

> *"It is certain that if we don't lead in may of these reform implementations, we will most surely be led by non-physicians with the ultimate losers being our patients."*

today are either medical specialty approved ones or those developed by the AHCPR.

A number of states have enacted legislation similar to Kentucky, especially Maine, Florida, and Minnesota. In most cases the stated purposes are to *reduce health care costs and preserve quality.* In Florida, an appointed physician advisory committee has approved 171 practice parameters for general use. Generally physician use of practice parameters is made voluntary, but at least preliminary results indicate that physicians have not found the parameters to be overly intrusive or compromising to quality of care. Well structured parameters offer multiple options and include categories such as *always indicated, sometimes indicated,* and *never indicated.* Many diseases are so complex that it will be impossible to develop useful practice parameters.

Several health insurance companies are developing policies that will require physician use of practice parameters in order to participate. An example of that approach is the Illinois Blue Cross/ Blue Shield program with several parameters in place and others being developed. In addition, there are some 12 state medical society affiliated liability insurance companies requiring practice parameter use or offering considerable incentives to physicians who will use practice parameters in an effort to reduce liability suits.

One potential use of practice parameters is to reduce malpractice suits and defensive medical practice. HB 250 states that any provider who has followed the practice parameters shall be presumed to have met the appropriate legal standard of care regardless of unanticipated complications that may develop. A demonstration project enacted in Maine in 1990 and implemented in 1992 goes further. It states the above and that the physician may use practice parameters for legal defense in a suit, but the plaintiff may not. The main project involves 4 specialities (Obstetrics, Radiology, Anesthesiology, and Emergency Medicine) and 20 practice parameters. Ninety percent of Maine physicians in those specialties are participating in this 5-year study. To date there have been no suits filed, and survey of participating physicians indicates a high approval rate and the belief that lower costs will come more from improvement in quality of care resulting in fewer suits than from the "affirmative" defense clause. Needless to say, several more years will be required to determine if practice parameters are helpful or harmful to physicians in liability issues.

> *"It behooves us physicians to know more about practice parameters or alternately called practice guidelines."*

There are certainly many problems to be resolved in practice parameters development and use. Standardized structure and vocabulary are needed. The marked diversity in diseases, co-morbid conditions, and individual responses to treatment along with even different but acceptable options in treatment will be difficult to resolve. A major hurdle will be to keep parameters updated with the most current diagnostic and therapeutic options. It is very possible that practice parameters will inhibit medical research and development of new and better patient care strategies. It will be imperative that all approved parameters continue to allow physicians adequate flexibility to adjust care to fit individual patients. We must not forget that we *physicians* are ultimately responsible for the care delivered, regardless of any published parameter.

In Kentucky, preliminary discussions of practice parameters development and implementation began in October 1994 with KMA physicians and staff invited to participate. It is my opinion that we physicians must not only participate, but assume a major leadership role in this important process. Having reviewed many of the 70 published practice parameters in Cardiovascular Diseases, I can assure you that the vast majority of our practices will not be altered by well developed parameters. This may in fact be an opportunity for us to help reduce variation in practice habits, reduce unnecessary medical care, and yet maintain quality while at the same time reducing the cost of care and possibly decreasing liability suits and defensive medicine. It is certain that if we don't lead in many of these reform implementations, we will most surely be led by non-physicians, with the ultimate losers being our patients.

Robert R. Goodin, MD
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Newborn Hearing Screening

Dan L. Stewart, MD; Adele Pearlman, RN



Congenital deafness is a relatively common problem with an incidence of 1/300 to 1/1000. Most states have no mass screening program for hearing loss, but the state of Kentucky compiles a High Risk Registry which is a historical survey of parents relating to risk factors for hearing loss. Unfortunately, this survey can miss 50% of those who have a hearing deficit. If not detected prior to discharge, there is often a delay in diagnosis of deafness which prevents early intervention. We report 2 years' experience at Kosair Children's Hospital where 1,987 infants admitted to well baby, intermediate, or intensive care nurseries were screened using the ALGO-1 screener (Natus Medical Inc, Foster City, CA) which is a modified auditory brain stem evoked response (ABR). Our screening of this population led to an 11% incidence of referral for complete audiological evaluation. There were no significant complications. Forty-eight infants were found to have nonspecified, sensorineural, or conductive hearing loss. The positive predictive value of the test was 96%. Therefore, we feel that the use of the modified ABR in the newborn is a timely, cost efficient method of screening for hearing loss and should be used for mass screening of all newborns.

Forty years of documentation shows early identification of hearing impairment is critical in preventing speech and language delays, as well as psychosocial and cognitive delays.[1] Hearing loss does not have to be severe to result in educational and economic harm to the individual. Medically, these infants are often misdiagnosed as mentally retarded, autistic, brain damaged, or schizophrenic. The mean age at diagnosis of profound congenital deafness is 24 months.[2] Mild to moderate delays are not diagnosed until an average of 43 months of age,[3] since the indicators of hearing impairment during early childhood are somewhat subtle behavioral clues rather than medical symptoms.[4] The estimated overall risk for congenital deafness is 1 in 300 to 1 in 1000.[5,6] A recent study of normal newborns found an incidence of 3.5% of infants failing the initial hearing screening using the modified auditory brain stem evoked response.[7]

Because of the likelihood of missing high risk infants with hearing impairment by using outmoded testing and the poor compliance of parents returning to the audiologist for hearing screening, we conducted a 2-year study using an ABR on all infants admitted to the neonatal intensive care unit and the intermediate care nursery before transfer or discharge home. We also screened newborn infants during the second year of the study.

From the Department of Pediatrics, University of Louisville School of Medicine and Kosair Children's Hospital, Louisville, KY 40292.

Newborn Screening and Joint Commission on Hearing Position Statement

Despite the frequency of occurrence, 92% to 95% of infants born in the United States are not screened for hearing losses.[8] However, metabolic conditions are less frequent but are routinely screened at birth. Lack of recognition of the scope of the problem and cost considerations are the major factors in the absence of newborn hearing screening. According to The Joint Commission on Infant Hearing 1990 Position Statement,[9,10] risk factors for sensorineural hearing impairment include:

1. Family history of congenital or delayed onset childhood sensorineural impairment
2. Congenital infection
3. Craniofacial anomalies
4. Birth weight less than 1500 grams (~3.3 lbs)
5. Hyperbilirubinemia exceeding indication for exchange transfusion
6. Ototoxic medications
7. Bacterial meningitis
8. Severe depression at birth
9. Prolonged mechanical ventilation for ≥10 days
10. Stigmata of a syndrome known to include sensorineural hearing loss (eg, Waardenburg)

The Joint Commission also recommends that if an infant cannot be tested prior to discharge, an ABR should be performed at 3 months and no later than 6 months of age. When hearing loss is identified, early intervention services should be provided according to Public Law 99-457.[10] Early intervention services should include the following:

1. Evaluation by a physician with expertise in the area.
2. Evaluation by an audiologist to determine the type, degree, and configuration of the hearing loss, and to recommend assistive communication devices appropriate to the child's needs (eg, hearing aids, personal FM systems, vibrotactile aids).
3. Evaluation by a speech-language pathologist, teacher of the hearing-impaired, audiologist, or other professional with expertise in



KENTUCKY HEARING RISK CERTIFICATE

Print Clearly or Type Information

Baby's Name _____ D.O.B. ____/____/____ Sex ____

Parent/Guardian _____ Address _____

Telephone # _____ City _____ State _____ Zip _____

County _____ Birth Hospital Code _____

Name of Physician/Clinic/Health Department that will follow the Baby for Well Child Care

Name _____ Address _____

City _____ State _____ Zip _____

CHECK THE BOX AND COMPLETE FOR EACH APPLICABLE CRITERIA

1. ☐ BIRTHWEIGHT/GESTATIONAL AGE: Birthweight three pounds or less. (Weight. ____lbs.____ozs.)
   Gestational Age 36 weeks or less. (GA in weeks _____.)
2. ☐ INFANT HAD: Blood transfusion for hyperbilirubinemia _____.
   Bilirubin level equal to or greater than 1BMG% _____.
3. ☐ LOW APGAR SCORES: 1 minute APGAR score 3 or less. (1 minute APGAR score _____.)
   5 minute APGAR score 5 or less. (5 minute APGAR score _____.)
4. ☐ BIRTH DEFECTS: Ear _____; Nose _____; Palate _____; Other (Specify) _____;
   Craniofacial Anomalies/Syndromes (Specify) _____.
5. ☐ DID THE NEWBORN INFANT HAVE: Sepsis _____; Seizures _____; Meningitis _____.
6. ☐ AMINOGLYCOSIDES GIVEN TO THE INFANT: Duration greater than three days _____.
   Peak Level greater than 10 ug/ml _____.
   Trough Level greater than 2 ug/ml _____.
7. ☐ PRE/PERINATAL CONDITIONS: Mother exposed to Rubella _____; Cytomegalovirus _____.
   Toxoplasmosis _____.
   Mother had ACTIVE Chicken Pox Disease during pregnancy _____.
   Baby exposed to ACTIVE Herpes during vaginal birth _____.
   Other (Specify) _____.
8. ☐ BLOOD RELATIVE OF THE BABY WHO HAS HAD A PERMANENT HEARING LOSS SINCE CHILDHOOD.
   (Describe _____.)
9. ☐ PARENTAL CONCERN.
10. ☐ NONE OF THE ABOVE.

DATE OF INFANT'S DISCHARGE/TRANSFER ____/____/____. TRANSFERRED TO NICU/ICU: YES____ NO____.
GIVE NAME OF NICU/ICU _____.
WAS THE INFANT: LIVING ____ AND SENT HOME ____ OR UP FOR ADOPTION ____. EXPIRED ____.
WAS THE INFANT'S HEARING TESTED: YES____ NO____. RESULTS OF TEST _____.

SEE REVERSE FOR FURTHER INSTRUCTIONS

1-1-91

PLEASE DETACH AND GIVE TO ALL PARENTS

Dear Parent:

As of September 1, 1986 each baby born in Kentucky is required by law to have a Hearing Risk Certificate completed. Some questions on this certificate will be answered by you, and some questions will be answered from the results of your baby's physical examination by the doctor.

On the back of this notice are the guidelines for normal hearing development. Please keep this notice. If there are any questions about your infant's ability to hear, ask your baby's doctor and have your baby's hearing tested. Hearing can be tested anytime after birth.

For further information on the High Risk Registry or where to have your baby's hearing tested, call the Kentucky Commission on the Deaf and Hearing Impaired toll free at 1-800-372-2907 (voice or TTY).

SEE REVERSE SIDE

Fig 1 — The Kentucky Hearing Risk Certificate.

the assessment of communication skills in hearing-impaired children, to develop a program of early intervention consistent with the needs of the child and preferences of the family. Such intervention would be cognizant of and sensitive to cultural values inherent in familial deafness.

4. Family education, counseling and guidance, including home visits and parent support groups to provide families with information, child management skills, and emotional support consistent with the needs of the child and family and their culture.
5. Special instruction that includes:
   a. the design and implementation of learning environments and activities that promote the child's development and communication skills;
   b. curriculum planning that integrates and coordinates multidisciplinary personnel and resources so that intended outcomes of the Individualized Family Service Plan (IFSP) are achieved; and,
   c. ongoing monitoring of the child's hearing status and amplification needs and development of auditory skills.

In the state of Kentucky, infants at risk for hearing loss are identified by the High Risk Registry (HRR). An example of the Kentucky Hearing Risk Certificate is included in Fig 1. The HRR closely resembles the Joint Commission on Infant Hearing Statement. Historical data obtained from the parents is used to identify infants who need hearing evaluation. Studies show the HRR can miss up to 50% of infants with sensorineural hearing loss, since many of these infants do not exhibit any risk factors and the system misses a significant number of children with risk factors.[11] Therefore, this method of mass screening is not felt to be the optimal screening tool and may open the door to electrophysiologic testing in the future. Although many states are considering hearing legislation at this time, Kentucky was one of the first states to mandate any form of screening.

Insurance companies are recognizing the importance of hearing screens, but reimbursement for testing still depends largely on the institution and the state. The economic impact —$23.4 billion spent on communicative disorders in 1986 — can be reduced by early recognition and appropriate intervention.

Another reason for routine screening is obvious when evaluating the HRR statistics for the



Fig 2 — The ALGO-1 automated evoked response infant hearing screener.

state of Kentucky in 1991.[12] The total number of HRR certificates received was 53,145. The number of infants at risk was 6,401, but only 2,084 referrals were tested or parents completed postcards stating that their infants did not have a hearing problem. The above statistics revealed that only 33% of the total at risk were screened. Considering the expected rate of 1 in 50 infants with hearing loss in those at risk, this raises concern for the greater than 4,000 infants who were not evaluated. There would be approximately 80 infants who may indeed have some degree of hearing loss.

Methods

Advances in technology have affected the health arena in many ways. This valuable partnership of technology and medicine has aided diagnosis, treatment, and management of a wide variety of diseases and disorders. An example of this technological advancement is the ALGO-1 (modified auditory brain stem evoked response) used to screen newborn infants for deafness.[13]

This highly sensitive, automated device (Fig 2) incorporates systems for stimulus generation, EEG, ambient noise detection, and myogenic noise rejection, all integrated via a central microprocessor. This test is administered at the bedside by placing three electrodes in a montage on the infant's head. Ear couplers are placed over the ears. A 35 decibel click is generated and the response is compared with an internally stored template. A "pass/refer" test response is produced. Sensitivity and specificity measures for the ALGO-1 unit are reported as 100% and 96%, respectively.[14]

At Kosair Children's Hospital, newborn hearing screening was initiated in February 1991 using the ALGO-1. Registered nurses were trained to perform the testing, and all infants admitted to NICU or intermediate care nurseries were tested using the algorithm in Fig 3. Some newborns were screened during the second year of the study.

Results

Results of screening using the ALGO-1 screener are found in Table 1. Prior to doing test 2, otoscopy was performed by a physician in 203 of the 221 patients who referred on the initial test. After this exam 104 infants subsequently passed, which reduced the number of infants requiring referral to the audiologist.

Each patient was given a card with developmental milestones to monitor future speech development. Infants with test response of "refer" received otoscopy, and if "refer" on retesting,

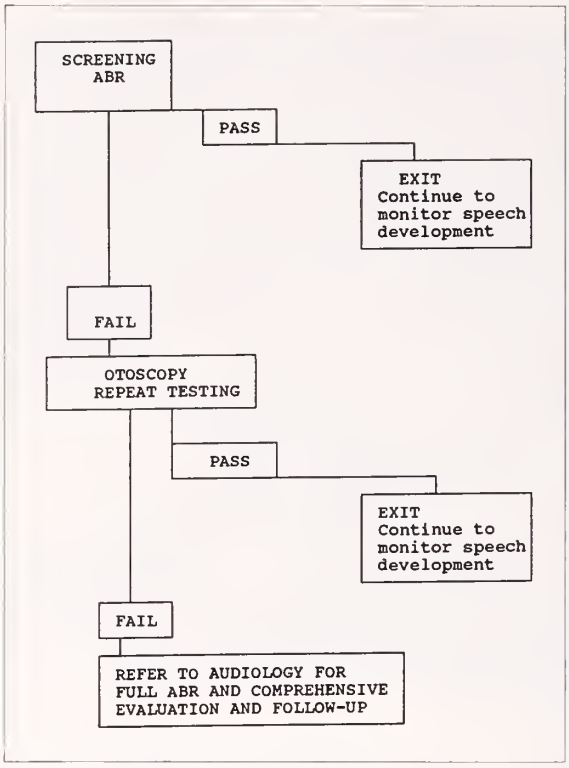


Fig 3 — Algorithm for screening infants.

they were given appointments for comprehensive evaluation by an audiologist. "No shows" for follow-up were sent two other appointments. This was followed by certified letters stating the need for compliance and the parental responsibility. Results of follow-up for the infants who referred are in Table 2.

Therefore, the prediction rate of positive screening test is 96% with the exclusion of deaths and those infants who were not retested. The average time for completion of testing was less than 30 minutes and the only complications have been skin abrasions. The cost to the patient is $75.

Discussion

Most physicians are unaware of the primary issue of early hearing impairment and how the condition interferes with the normal progression of a child's language and psychosocial development and the fact that early diagnosis is both possible and essential.[15] The state of Kentucky is very progressive in the field of hearing by being one of the first states to mandate screening using the HRR, but the compliance with follow-up testing has been dismal at best.

Table 1. Screening Results for 1,987 Infonts

	No.	Percentoge
Poss (Test 1 & 2)	1766	89
Refer	221	11
Biloterol	90	41
Right Only	67	30
Left Only	64	29

Table 2. Follow-up of 221 Infants Referred on Initiol Testing

Normal	88
Sensorineurol heoring loss	13
Conductive heoring loss	16
Non-specified heoring loss	22
Deaths	4
Unknown or no follow-up	78

The advantages of the ALGO-1 are: (1) simplicity of use; (2) test is done at the bedside wi[th] out sedation; (3) low cost; and (4) markedly improved sensitivity and specificity over other available tests. The value in performing otoscopy is reflected in the 51% of patients who passed after the examination. This suggests that the ear canal is often collapsed or filled with inspissated amniotic fluid in many infants.

Every practicing pediatrician needs to be aware of this new technology which provides state-of-the-art hearing testing with low false positive rate on a captive audience. This test should be considered for all infants, since it will identify those infants who need intervention at an early age and improve the quality of life for those identified. The 1993 Joint Committee on Infant Hearing recently endorsed the concept of universal hearing screening of infants prior to 3 months of age to ensure that all infants are identified and intervention is initiated by 6 months of age.

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Acute Miliary Blastomycosis in an AIDS Patient

Latha Srinath, MD; Sunket Ahkee, MD; Anna Huang, MD
Martin J. Raff, MD; Julio A. Ramirez, MD

From the Division of Infectious Diseases, Department of Medicine, School of Medicine, University of Louisville, Louisville, Kentucky.

The incidence of blastomycosis in immunocompromised patients with HIV infection is very low when compared to other mycoses. Of the 19 cases of blastomycosis described in HIV-infected patients, only four had a miliary pattern on chest x-ray. A case of acute miliary blastomycosis in an HIV infected patient from Louisville is described.

A 43-year-old AIDS patient with a CD4 lymphocyte count of 43/mm3 (5%) was admitted to the hospital with a 2-week history of fever, chills, dyspnea, and worsening cough. Admission chest x-ray showed bilateral perihilar infiltrates. Sputum Gram's, acid fast, KOH and GMS stains were nondiagnostic. Empiric therapy for presumed *Pneumocystis carinii* pneumonia was begun. Chest x-ray on day 3 was remarkable for a miliary pattern. Numerous white plaques in the left main bronchus were seen at bronchoscopy. Bronchial washings and biopsy showed budding yeast on calcofluor white stain. Cultures grew *Blastomyces dermatitidis*. Oral ketoconazole therapy was started.

While the presence of a miliary pattern on chest x-ray in an HIV infected patient suggests a diagnosis of tuberculosis or histoplasmosis, clinicians must be aware of blastomycosis presenting in this fashion.

Blastomycosis is an endemic fungal infection which occurs sporadically in the midwestern and south central United States. The disease is initiated by inhalation of conidiospores which evolve into budding yeasts in the lung. Because of the lack of reliable skin tests and serology our understanding of the epidemiology of blastomycosis is primitive. Cases have been reported in normal and immunocompromised hosts. The latter are predominantly patients with underlying malignancies or those receiving corticosteroids.[7,8] A case of acute miliary blastomycosis in a patient with AIDS is described.

Case Report

A 43-year-old homosexual AIDS patient with a bipolar disorder, prior giardiasis, and esophageal candidiasis presented with 1 month of nonproductive cough and malaise, and 2 to 3 days of fever, chills, dyspnea, and worsening cough. On admission to the hospital he denied headache, nausea, diarrhea, abdominal cramps, hemoptysis, skin lesions, and exposure to tuberculosis.

He was a malnourished cachectic man in mild to moderate distress, febrile to 103°F; pulse 120/min, respirations 32/min; and blood pressure 128/84 mm Hg. Ocular examination including fundoscopy was normal; there was a tender nodule palpable under his upper lip. The neck was supple without adenopathy. Occasional rales were audible throughout both lung fields. He was tachycardic with a grade 2/6 systolic murmur at the left sternal border. The skin was hot but free of lesions. Abdominal, rectal, and neurological examinations were within normal limits.

The WBC count was 3,600/mm3 with 77% neutrophils, 11% lymphocytes, 8% monocytes, and 4% bands. The serum sodium was 129 meq/L, and glucose 100 mg/dl; other automated blood chemistries were normal, as was the urinalysis. Room air arterial blood gases showed a pH 7.49; P_{O_2} 75 mm Hg and P_{CO_2} 28 mm Hg. The CD4 lymphocyte count was 43/mm3 (5%). Inappropriate secretion of ADH was not demonstrated. Chest x-ray showed bilateral perihilar interstitial infiltrates (Fig 1). Panorex and sinus x-rays were normal.

Sputum Gram's, acid fast, KOH and GMS stains were nondiagnostic. The patient was placed in respiratory isolation and screened for possible tuberculosis. He was started empirically



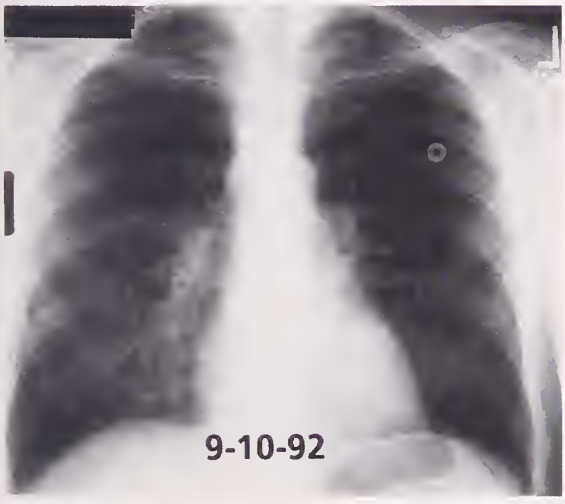


Fig 1 — Admission chest x-rays showing bilateral perihilar infiltrates.





Fig 2 — Chest x-rays showing miliary pattern on hospital day 3.

on intravenous trimethoprim/sulfamethoxazole (TMP-SMX), for presumed *Pneumocystis carinii* pneumonia. Serologic tests including cold agglutinins, Legionella and respiratory viruses were negative. AFB smear and cultures were negative.

On the third hospital day, follow up chest x-ray showed a miliary pattern with nodules measuring 1-3 mm (Fig 2). Patient was asymptomatic and clinically showed no worsening in respiratory status. Bronchoscopy revealed numerous white

plaques in the left main bronchus. Bronchoalveolar washings and biopsy showed budding yeast on calcofluor white stain, and cultures grew *Blastomyces dermatitidis*. TMP-SMX was discontinued and oral ketoconazole was started at 400 mg/day. He began to improve clinically and there was clearing of pulmonary infiltrates radiologically 2 weeks after admission. Serologic tests for CMV, EBV, and Toxoplasma were negative. Immunodiffusion and complement fixation tests for fungi were not obtained.

Discussion

Blastomyces dermatitidis is endemic in the general area of the Ohio and Mississippi river valleys extending northward to include the Great Lakes. To date only 19 cases of blastomycosis have been described in HIV-infected patients.[1-5] Presence of whitish plaques (calcofluor positive for *B dermatitidis*) in the bronchus has not been previously described. The principal host defense mechanisms against this organism have not been fully defined. Possible explanations for the rarity of blastomycosis are discussed here.

1. Primary infection with *B dermatitidis* may be rare. True incidence and epidemiology of blastomycosis is unknown because of difficulty in isolating the organism from its natural habitat. The endemic areas have been mapped out only by individual case finding.[9,10] In addition no large epidemics have been described. If endogenous reactivation of a primary focus were to explain the higher incidence of histoplasmosis in the HIV-infected individual, the reservoir of patients with primary blastomycosis being small may account for a lower incidence of blastomycosis. Lack of reliable skin and serologic testing for *B dermatitidis* as compared with *H capsulatum* makes it difficult to determine the frequency of asymptomatic infections.

2. Although *B dermatitidis* has been classified under primary dimorphic pathogenic fungi, the organism may have low virulence and hence may require a larger inoculum in order to produce clinical disease, as compared with *H capsulatum* or *C immitis*.

3. In HIV-infected individuals almost every aspect of the immune system is affected, including helper/suppressor T lymphocyte function, B lymphocyte function, and monocyte-macrophage lineage. The paucity of reported cases may indicate that immune mechanisms or mediators may still be present in advanced HIV infection which protect the patient from blastomycosis.

In summary, it is still unclear why blastomycosis is a rare fungal infection in HIV-infected individuals. Initial presentation with acute miliary disease as described in our patient has been previously reported in four cases. As this disease is responsive to antifungal chemotherapy, a high index of suspicion should be maintained.

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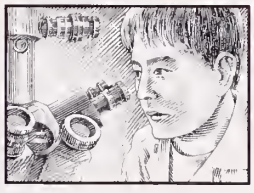
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Northern Exposure: A Look at the Canadian Health Care System

David A. Sloan, MD; Mark D. Wells, MD

From the Department of Surgery, University of Kentucky Chondler Medicol Center, Lexington, KY.

UNIVERSITY OF KENTUCKY
COLLEGE OF MEDICINE

The form that health care will take in the next few years is currently of great interest to Americans. Certainly, many Americans appear to be dissatisfied with their health care system. Annual US health care costs are approaching $1 trillion and, within 35 years, will account for 26% of the gross national product (GNP) if current trends persist.[1] In contrast, in 1970 the cost of health care was only 7% of the GNP.[2] The fact that 37 million Americans have no health insurance at all and 50 million Americans are under-insured has led to dissatisfaction with the current system.[3]

The cornerstone of President Clinton's current term is an overhaul of the health care system. One member of Congress described the need for health care reform as "desperate."[4] In a recent Harris poll, only 10% of Americans (in contrast to 56% of Canadians) believed that their health care system worked "pretty well."[5] On the other hand, 89% of Americans polled agreed with the statement "the American health care system requires fundamental change."[5]

There is much more agreement on the need for reform than on the manner in which reform will be achieved. Although the Clinton administration favors managed competition, a competing proposal in Congress is based on a single-payer system like that of Canada. Most Americans polled by Harris favor a health care system like Canada's.[5] A spokesman for the group Physicians for a National Health Care Program was recently quoted in the *New England Journal of Medicine* as follows: "Our health care system is failing . . . [I]t is time to change fundamentally the trajectory of American medicine. . . . *Our plan borrows many features from the Canadian National Health Program*" [italics ours].[6] The administration has made it clear that, although it favors managed competition, the opportunity for individual states to operate a single-payer system will be available. Indeed, states such as Vermont are moving in this direction.

What is so attractive about the Canadian Health Care Program? Why have so many American citizens, physicians, and politicians pointed to Canada as a model for the US health care system? Some of the reasons are probably quite obvious. The Canadian health care system appears to deliver good-quality health care to all of its citizens and at the same time appears to cost less. It is estimated that the per-capita, per-year cost of the Canadian health care system is $1800, whereas that of the American health care system is $2200.[7] Health care costs in Canada appear to be better controlled; the overhead costs for health care are substantially lower in Canada than in the US, by a factor of approximately 6.[8] Some researchers have estimated that $29.2 billion, or 8.2% of the total spending on health care, would be saved if the United States adopted a Canadian-style health care system.[9]

Certainly a very alluring picture can be, and has been, painted of the Canadian health care system. But is it really that attractive? Is it really the answer to the US health care crisis? Is there a dark side to the Canadian health care system? Does it really work? How did it get started? In which direction is it headed? Could such a system actually be imposed on the American people? These are all very valid and indeed pertinent questions, and in the light of the current political and social climate in the United States, these are all questions for which American physicians should be seeking answers.

The US and Canada: The Contrasts

The Canadian-US border is the longest undefended border in the world, and the individual histories of the United States and Canada have been linked for many years. The cultures and economies of the two countries are interwoven: Canada is the largest trading partner of the United States, and this relationship expanded with the

ratification of the North American Free Trade Agreement. The educational programs of the two countries are quite similar, and this is certainly true of medical education programs as well.

There are differences, however, between the United States and Canada, differences that are important when one views their respective health care systems. The United States won its independence by revolution, whereas Canada's independence peacefully evolved. In Canada, the government is much more decentralized. Compared to the individual states, the 10 Canadian provinces have much more control over their internal affairs. The Canadian psyche encourages *more* government, whereas the American psyche wants to see *less* government. "Peace, Order, and Good Government" might be a Canadian motto, whereas "Life, Liberty, and the Pursuit of Happiness" is a more appropriate slogan in the United States. Individualism, self reliance, and an entrepreneurial spirit are much stronger in the United States than in Canada. Canadians definitely incline more toward comprehensive social and educational programs. The United States is a cultural melting pot, whereas Canada's multiculturalism and bilingualism are emphasized. Canadians want to emphasize their differences rather than their similarities. For a demonstration of this fact, one has only to look at the province of Quebec, where nationalistic fervor has simmered for generations and now threatens to torch the Canadian fabric.

Our experiences as Canadian surgeons working in the US health care system have convinced us that American physicians and surgeons generally hold a number of misconceptions about the Canadian health care system. Some of the common misconceptions are that Canadian physicians are heavily regulated state employees, that waiting for procedures is like waiting for bread in the former Soviet Union, that bureaucracy is rampant, that the Canadian system is much more expensive, that Canadian physicians are poorly remunerated, and that the Canadian health care system is like one large Veterans Affairs (VA) hospital.

The History of the Canadian Health Care System

How did the Canadian health care system evolve? Perhaps the most important thing for Americans to know is that the evolution of the Canadian health care system has been a very gradual and incremental process, occurring over the past 50 years.

Canada became a nation in 1867. In that year, the British North America Act established that health care fell under the jurisdiction of the individual provinces making up the Confederation. In 1935 the federal government attempted to wrest this control from the provinces, but this move was soundly defeated. Proposals for federal subsidies to provincially administered health programs were first presented to the Canadian House of Commons in 1943 during World War II, but at a 1945 Federal-Provincial conference no agreement could be reached. Notwithstanding this deadlock, several provinces, beginning in 1947, proceeded with their own hospital insurance schemes. In 1946, the province of Saskatchewan, which has traditionally led the other provinces in health care programs, enacted the Saskatchewan Hospitalization Act, thereby establishing universal compulsory hospital coverage for all residents of Saskatchewan.

In the 1950s, the provinces placed increasing pressure on the federal government for more action on health care at a federal level. This pressure culminated in the 1957 Hospital Insurance and Diagnostic Services Act. This act offered 50% federal funding for provincial expenditures on medically necessary hospital care. To receive federal monies, the provincial governments had to provide comprehensive inpatient services, and they had to assure universal coverage. This act, in fact, established the pattern for implementing universal health care in Canada; federal funds would only be transferred to the provincial health care plans if the provinces showed that they were complying with all of the stipulations of a given federal or national act.

By 1961, universal, government-run hospital insurance programs were in place in all 10 provinces and two territories of the nation. It was not long before physicians' services were covered by government-run insurance programs. Physicians' services were first covered by Medicare in the Province of Saskatchewan, becoming law in 1961. However, the community of physicians was adamantly opposed to this measure and initially refused to cooperate. In fact, this legislation provoked the first physicians' strike in North America in July of 1962. The Saskatchewan physicians counted on substantial public support; when this support did not materialize, they ended their strike after 23 days, acquiescing to the legislation. This acquiescence established universal health

care coverage for both inpatient and outpatient services in the Province of Saskatchewan. The remaining provinces were left with the hospital-only scheme.

In Canada, royal commissions have historically been important vehicles for bringing issues very important to the country as a whole into the spotlight of public debate. In 1964, under the supervision of Chief Justice Hall, a royal commission made a number of recommendations on the subject of health care. In essence, the Hall Commission recommended implementing a universal health care program. It should be noted that the Canadian Medical Association (CMA) was surprised by this recommendation and was bitterly opposed to it. The CMA in fact recommended that a health care scheme be worked out with private health care insurance carriers, and advocated a tax credit system along the lines of that being discussed in the United States today.

The objections of the CMA notwithstanding, the landmark recommendations of this Royal Commission were carried out, taking the form of the Medical Care Act of 1966. This Act dictated that the federal government would provide 50% funding for health care programs, provided that the individual provinces and territories met five essential stipulations with their provincial health care programs. The health care programs had to be *universal*, had to provide *comprehensive* services, had to be *portable* (ie, patients could carry their health care privileges from one province to another), had to be *publicly* and not privately administered, and finally had to provide *reasonable access* to insured services for all Canadian citizens.[5] Again, each province had to implement its own health care program, and this was a relatively slow process. Implementation of these universal health care programs began in 1968; by January 1, 1971, the programs were in place in all provinces. The implementation of these universal health care programs met with opposition from groups of physicians, but ultimately all physicians were forced to accept it.

In 1977, the Extended Health Care Services program covered other health services not previously covered, such as home nursing and other support services. In 1984, the Canada Health Act consolidated previous health care laws, including the 1966 Medical Care Act. One of the stipulations of the Canada Health Act, and indeed one of the motivating forces behind it, was that federal monies would be substantially reduced for any provincial health care system allowing extra billing by physicians or allowing user fees. In fact, the reduction in monies would be equal to the amount paid out of pocket by patients in those particular provinces. The Canada Health Act was duly passed in Parliament with overwhelming support by members of all political parties.

The Canadian Health Care Delivery System Today

As has already been mentioned, each province and territory has its own health care system; thus, one cannot really refer to the Canadian Health Care system, because it is in fact a dozen health care systems. The federal government, because of financial constraints, no longer matches the expenses of the individual provinces but now sends a block grant to each province provided the provinces meet the criteria set forth in the Canada Health Act. Since 1977, the federal government has limited the amount of money that has been sent to each province, and this has had the direct impact of requiring each province to assume more and more of the burden of health care. In fact, new federal legislation, Bill C-69, "The Government Expenditures Restraint Act," will eliminate these transfers to the provinces over the next several years. The cash transfers will disappear at different times in various provinces. Their elimination can be calculated to occur as early as 1995 in Quebec and between 2002 and 2010 for the remaining provinces. The end result of Bill C-69 could be loss of standardization of health care across the country, because the federal lever over the provinces would be lost.

At the present time, the Province of Ontario devotes approximately *one third* of its entire provincial budget to health care.[10] Interestingly, the federal contribution to total health care spending in both Canada and the United States is currently 29%. It is therefore critical to realize that, if a Canada-style health care system were to be implemented in the United States, the *entire* burden would have to be placed on the individual states, a burden that would obviously incur a substantial increase in state taxes.

Although each Canadian Province has its own health care program, the programs have a number of common features. First, all physicians are either opted in *or* out of their respective provincial plans. Virtually all hospitals in Canada are public, so an individual physician or surgeon would have an extremely difficult time making a

living outside of any of the provincial health care plans. For this reason, only a handful of physicians have opted out of these plans.

It is *illegal* for a physician to bill patients both privately *and* within the universal program. Because private health care carriers are forbidden to cover services that are covered by the provincial health care plans, patients are unable to obtain insurance for most medical services. Physicians bill each provincial health care plan for all inpatient and outpatient services. Because there is only one insurance carrier, namely the provincial government, billing procedures are standardized, and administrative costs are much lower than in the United States. Many physicians submit bills to the provincial government daily by accessing the government computers through their personal computers and modems. Physicians receive payment fairly rapidly, and, of course, because everyone is covered, virtually 100% of billings are remunerated.

When one compares health care in Canada with health care in the United States, one must look in detail at the fabric of the health care system in Canada. Although the number of physicians per capita is virtually identical in the two countries (about 200 per 100,000 population), a far greater percentage of the total Canadian physician population is made up of family or general physicians (52% in Canada, compared to only 13% in the United States, where there are far more specialists).[11] Much has been made as well of the significant differences between Canada and the US in the percentage of individual surgical specialists. For many of the specialities, there are twice as many specialist physicians in the United States as in Canada.[11] There is no question that, in a government-directed universal health care system, individual family or general physicians play a central role that is very much encouraged by the government. As Charles Daughtery has stated, "the widespread ability to identify a primary care physician as the usual source of health care and to have access to that physician in his or her office are structural marks of quality health care."[12]

How do hospitals run in Canada if they are virtually all public hospitals? Hospitals receive a fixed amount from the provincial government for operating expenses. Any capital expenses must be negotiated separately with the government. For example, if an institution wants to acquire a computerized tomography scanner, *even* if the money is available, the capital expenditure must be negotiated with the government.

Canada has approximately 20% more beds per 1000 population than the United States, and the bed occupancy rate is higher (82% vs 64%), meaning that hospital stays in Canada are longer (10.8 vs 7.1 days).[11] Currently, preauthorization before admission does not exist, nor is there a Canadian equivalent for Diagnosis Related Groups (DRGs). Hospital admissions per population are higher in Canada than in the United States (141 vs 134 per 1000 population).[11] Also interesting is the fact that 23% of hospital beds in Canada are set up for chronic care.[11] Therefore, one finds that, in many Canadian teaching hospitals, a significant number of beds in acute wards are devoted to chronic care.

How has universal health care benefited Canadians? Interestingly enough, when universal health care was implemented, the percentage of Canadians with no health insurance was greater than that among US citizens today. Approximately 20% of Canadians had no health insurance; in fact, most of the citizens in the province of Quebec had no health insurance. Further, the 1964 Royal Commission on health care determined that even those patients who did have insurance were very inadequately covered.[13] Although there were not as many insurance companies as now exist in the US (about 1,500) and the population was one-tenth that of the US, hundreds of private health care carriers existed in Canada before universal health care was established.[13]

Since Canadian "Medicare" (as universal health coverage is commonly referred to by the average Canadian) was introduced, life expectancy has increased and infant mortality has decreased.[12] Before the introduction of universal health care, infant mortality was higher in Canada than in the United States; currently, the infant mortality rate in Canada is 10% less than that in the United States. Although Canadians may grumble about their medical services, the facts remain that all Canadians have access to good health care and that no Canadian runs the risk of being bankrupted by catastrophic illness.

Is the Canadian Health Care system expensive? The answer, in a nutshell, is yes. There is no question that the overall tax burden in Canada is higher and that this is in large part due to the Canadian health care system. Although Canada spends less of its GNP on health care than does the United States, a greater percentage of *nondefense expenditures* goes to health care in Canada.[11] The individual provinces are forced to

spend a greater percentage of their budgets on health care. Currently, at least 30% of non-federal spending in Canada goes to health care, in contrast to 18% in the US.[11] Canada, it should be noted, spends more per capita on health care than any other country with a national health care system.

What has been the impact of the introduction of universal health care on physician income? As one might expect, one of the reasons for physicians' resistance to the introduction of a single-payer system was that their income would suffer. What is striking is the fact that the net income of individual physicians rose by 30% to 50% as soon as universal health care was implemented.[13] Obviously, there was more than one reason for this increase in income, but an important reason was the fact that, in general, physicians were receiving 100% of all billings. There is also good evidence that the billing activity by Canadian physicians has been greater since the introduction of the Canadian Health Plan than the corresponding billing activity of American physicians over the same time period.[8] The bottom line is that Canadian physicians and surgeons have not suffered financially as much as many American physicians and surgeons believe. The discrepancy varies from specialty to specialty, but there are in fact a few specialties, such as pediatrics, in which Canadian physicians appear to hold a slight advantage.[14]

A closer look at one of the provincial health care systems may be helpful. The province of Ontario is the industrial and manufacturing base of Canada. Ontario has vast natural resources, and its population is the largest of all of the Canadian provinces. Its economic health has traditionally been greater than that of the rest of the country. The economy of Ontario has actually outperformed those of Canada, the United States, and Germany over the past decade.[10] Ontario spent $17 billion on health care last year, and its health care expenditures are growing at an annual rate of 11%.[10] Fully one third of the provincial budget goes toward health care.[10] Unquestionably, there is increasing concern within the province that the health care system as it currently exists is becoming unaffordable. If the richest of the Canadian provinces cannot afford its health care system, what will happen to the poorer provinces?

Twenty thousand physicians practice in the Province of Ontario, and 25% of the health care budget goes in direct payments to these physicians.[10] The Ontario Health Insurance Plan (OHIP) allows for no premiums, no deductibles, no user fees, and no over- or extra-billing. Premiums are paid by every employer in the province, from general taxation and from federal transfer payments to the province. These federal transfer payments have been decreasing, and currently account for only 33% of health care expenditures in the province.

The Ontario Plan covers not only inpatient and outpatient expenses and physician fees, but also ambulance services, physical therapy, occupational therapy, and even chiropractors. Items such as prosthetics and wheel chairs are also covered. Also, for patients over the age of 65, all medications are paid for. Care received in a chronic care facility is covered, as are transportation costs from remote areas to areas of service.

The fees for medical services and for physician services are negotiated by the Ontario Medical Association, in which membership is mandatory. The most recent agreement between government and physicians provides for fair and independent binding arbitration between the doctors and the province in the case of a dispute. The new agreement also establishes a joint management committee composed of members both of the Ontario Medical Association and the Ontario government. One of the goals of this new joint management committee is to give both physicians and government members a voice in determining the future direction of health care in the province.

The concern about the cost of health care is very apparent in Ontario. A new socialist government elected in 1990 is attempting to throttle back the growth rate to 5.5% annually. This has resulted in serious cutbacks within the provincial system. The Ontario Hospital Association estimates that 5,000 jobs will be lost and 3,500 beds will be closed over the next 2 years.[10] It is also estimated that 30 hospitals might disappear through mergers and closures. Certain expenditures have increased significantly, such as hefty salary increases for nurses, pay equity, and operating expenses. Because the hospitals have received only a 3% increase in the last 3 years to cover these increased expenses, without question there has been a "money crunch." In an attempt to streamline operating expenses, the Province of Ontario has tended to centralize services to regional centers and to ration expensive resources. For example, waiting lists and delays of up to 8 months for elective cardiac surgery have been recorded.

The Future

In what direction is the Canadian Health Care System headed? The "money crunch" occurring in the Province of Ontario, the richest of the Canadian provinces, is mirrored in the other provinces, but in the sister provinces the financial problems are further magnified. The elimination by Bill C-69 of federal health care transfer payments to the provinces will have a tremendous impact on the already overburdened provincial health care systems.

Financial restraints have already been felt in the area of high technology. A comparison between the United States and Canada for a number of high-technology medical care items reveals a striking disparity. For example, there are 0.46 magnetic resonance imaging (MRI) units per million population in Canada, in comparison to 3.69 units per million population in the United States.[11] In fact, there are more of these machines in the state of Washington than in all of Canada.[15] Radiation therapy units are far more plentiful in the United States, as are cardiac catheterization laboratories. Canada has only 14 hospitals at which organ transplantations are performed, compared with 319 in the United States. Facilities offering open heart surgery are 18 times more prevalent in the US than in Canada.[16]

The limitation of high-technology resources has led to much-publicized waiting lists for Canadians awaiting procedures such as cardiac bypass. The plight of an insulation worker in the city of Vancouver, British Columbia, resulted in negotiations between the province of British Columbia and four Seattle hospitals to provide cardiac surgery services.[17] Having become frustrated with a wait for cardiac surgery in Vancouver, this man ended up paying out of his own pocket for his cardiac surgery at a Detroit hospital.[17] The amount of money paid by the Ontario Health Insurance Plan to US hospitals and physicians in 1990 was $214 million, a 45% increase over the previous year.[18] Approximately 40% of this money was paid in the state of Florida.[18] Other health care services for which there is a waiting list in Canada are hip replacements, cataract surgery, and drug addiction programs. Recent conversations between the authors and Canadian colleagues indicate that waiting lists for elective and semi-elective surgery are becoming longer.

One has only to look at recent headlines in Canadian magazines and newspapers to become aware that there is a problem in the Canadian Health Care System: for example, "Need surgery, medical tests; Go to the end of the line."[19] A much discussed lead article in *MacLean's* magazine was entitled "Sick to death, caught between rising costs and more restraints, hospitals are cutting services."[20] The Quebec Government will be making huge cuts in health care spending over the next 3 years, a plan that has been described as a "dismantling of the public health system."[21]

Despite the current difficulties in the Canadian health care system, the average Canadian, it would appear, is satisfied with his health care. Few desire a return to the US style of health care. Certainly, the expectations of Canadians are high. An Ontario resident recently wrote to the editor at the *Windsor Star* that "the people of Windsor and of Ontario have a right to expect that their medical system will provide them with the *best care* at *no cost* [italics ours]."[22] This rather simplistic statement typifies the attitude of the average Canadian, who, while he currently believes that he is being relatively well served, may in future years become distressed if the current trend in the health care system continues.

Conclusions

In conclusion, the Canadian Health Care System *evolved* over a long period of time and is very much *tailored for Canadians*. This system appears to provide good care to all Canadians. Although a Canadian may have to wait to see a specialist or sub-specialist, he still is not restricted as to whom he may see in consultation. There is no HMO "gatekeeper" to block access to specialist care; the only gatekeeper is the waiting line. Although the system is unquestionably expensive, the costs are shared, as manifested by an increased tax burden for the average Canadian.

Physicians in Canada are adequately compensated, although to a lesser degree than in the United States. Canadian physicians are less subject to malpractice liability and do not have to deal with a myriad of insurance companies. Canadian physicians are also free from preauthorization constraints and DRGs. There is also no question that in the Canadian system it is easier and in fact essential to designate centers of excellence.

The Canadian system, on the other hand, is more rigid and certainly to some degree discourages entrepreneurship and research and development. High-technology resources are much more limited, and this limitation is unquestionably leading to rationing of health care in Canada. Cana-

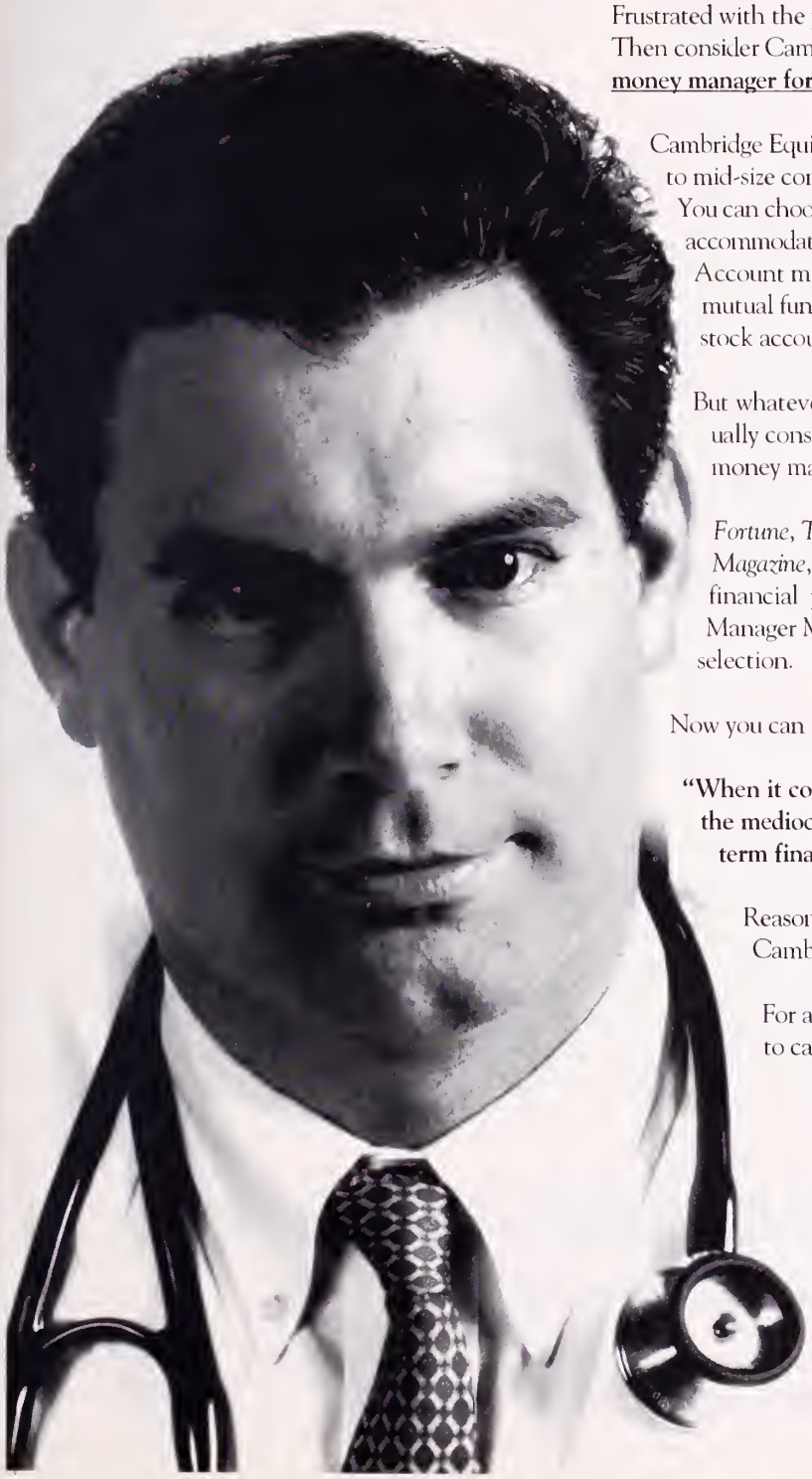
da's health care system clearly is heading toward it own crisis. In fact, a symposium at the 1993 meeting of the Royal College of Physicians and Surgeons of Canada addressed the Canadian health care crisis. There is even talk of setting up a private hospital system, talk that would formerly have been considered heretical. Under the Canada Health Act, such a system is currently illegal.

Although Americans can learn much from the Canadian Health Care System, the authors do not believe that the Canadian system will lend itself to the US. Controlling costs by limiting the availability of technology is not within the scope of American sentiment; moreover, there exists in the US a fundamental distrust of central government control over the lives of American citizens. Our opinion is that the Canadian Health Care System would have to be drastically altered before it would mesh with the American psyche.

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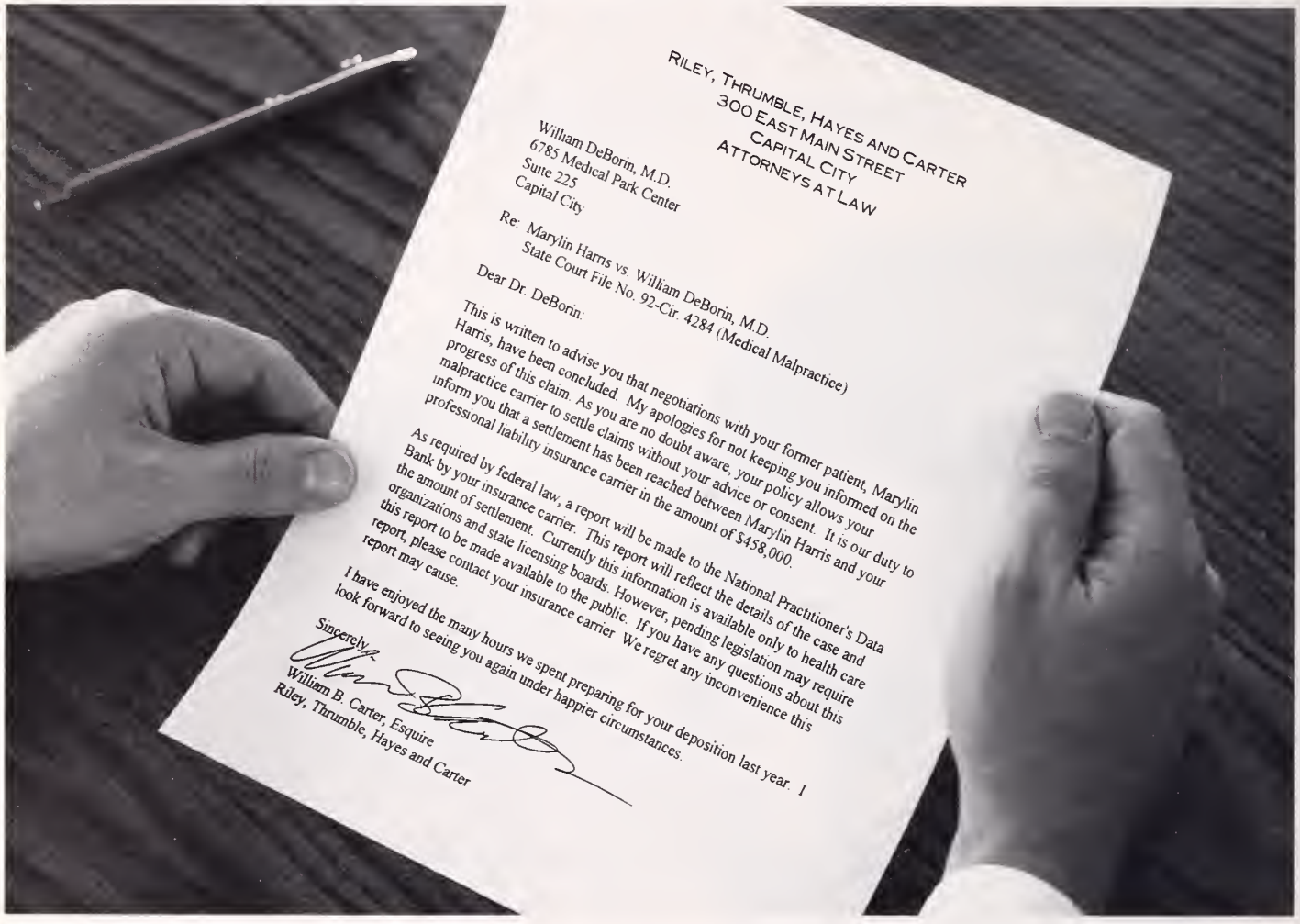
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William DeBorin, M.D.
6785 Medical Park Center
Suite 225
Capital City

Re: Marylin Harris vs. William DeBorin, M.D.
State Court File No. 92-Cir. 4284 (Medical Malpractice)

Dear Dr. DeBorin:

This is written to advise you that negotiations with your former patient, Marylin Harris, have been concluded. My apologies for not keeping you informed on the progress of this claim. As you are no doubt aware, your policy allows your malpractice carrier to settle claims without your advice or consent. It is our duty to inform you that a settlement has been reached between Marylin Harris and your professional liability insurance carrier in the amount of $458,000.

As required by federal law, a report will be made to the National Practitioner's Data Bank by your insurance carrier. This report will reflect the details of the case and the amount of settlement. Currently this information is available only to health care organizations and state licensing boards. However, pending legislation may require this report to be made available to the public. If you have any questions about this report, please contact your insurance carrier. We regret any inconvenience this report may cause.

I have enjoyed the many hours we spent preparing for your deposition last year. I look forward to seeing you again under happier circumstances.

Sincerely,

William B. Carter, Esquire
Riley, Thrumble, Hayes and Carter

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Maneuvering Medical Education

Medical education trains us. Definitely technical, sometimes humanitarian, and increasingly economic, this learning process starts at the earliest learning level and amplifies with time. The finished product — a physician — is at most the synthesis, and at least a by-product of this passage. Direction, like the wind currents, pushes us around pointing our teachers to make us different models for the times. Once, not very long ago, special training and more years to expand were emphasized and rewarded. Spectacular achievements needed physicians to incorporate their benefits into medical practice. Patients read eagerly that science had little to bind it, that the future care would be up to the mandate for longer life and more pursuit of happiness. Proof of that would be the growing older population, most of whom were not too infirm or weak of mind to enjoy and return their experiences to their progeny. That was the medical agenda of the time, and to some degree it still is. There are many journals, heavier books, and compact discs packed with gigabytes yearning for the computer screen and the graphic commands to access them. Information highways traverse the country and the world, with the phone lines as traffic lanes and the gasoline, modem signals. Now the information is not as much the problem as earlier in the century. The problem is that information breeds enthusiasm to drive, and the money to fuel this machine is evaporating.

Here comes that humanitarian part of the education, sticking us in the side and saying that people have needs, that their senses and their concerns are just as palpable as their body parts, and that to choose who among them will access this benefit from the information bonanza is a weighty decision. Sometimes I take off my white coat, either symbolically or physically, to reinforce my equality with my patients. My doctors ponder about me, but I stay concerned that their decision about me is free of monetary or care delivery considerations. They should be humane about me, and I should be humane about them and my patients. The humanities part of the educational experience inserts itself even more importantly in these times. Recall what has been and is being written about the human condition, about the living in different times, and the lessons, like a yo-yo, keep coming back up in the string spinning.

"What is missing is the enthusiasm for learning that students must contract. They should not be permitted to cast off the intellectual achievements of their predecessors, without at least feeling in their hands what can be done. They can be the fiduciary, without being the usurer. Practice economically responsible medicine, but also practice medically sophisticated medicine."

Then there is the economic. For a long time subterranean, but increasingly strident, the realities of bare budgets and stretched out taxpayers scream at us and are being heard in our medical schools. My teachers barely considered the costs and thought the administrators were functionaries who ran the operations, rather than the policies. More classes instruct about the marketplace, the care delivery, and the dictionary of terms for the medical system now evolving. Abbreviations increasingly signify payers, not medical lingo. There is an educational contraction, squeezed by the governors and representatives, to reduce the specialization and sometimes the time of medical education. This distillation should produce broader care to more people at less cost. Technical learning could profit more people, our humanitarian goal of making a life better all around reachable, and our economic expertise fitting into the budgetary straight jacket.

What is missing is the enthusiasm for learning that students must contract. They should not be permitted to cast off the intellectual achievements of their predecessors, without at least feeling in their hands what can be done. They can be the fiduciary, without being the usurer. Practice economically responsible medicine, but also practice medically sophisticated medicine. With more of us around and jobs engineered to be scattered everywhere, not magnetized to the city and the school, both these goals should be obtainable.

Stephen Z. Smith, MD

Epidemic of Litigation

TO THE EDITOR: Another year has gone by and as a society we do not seem any closer to reaching any consensus on our epidemic of litigation, which I believe may be responsible for as much as 50% of health care costs.

It is not clear to me why our society cannot accept the fact that individuals can make contractual agreements without giving attorneys free license to intervene at any time after the contract is made. On the one hand, opponents of our system of litigation will point out that the majority of suits are frivolous; proponents will say simply that physicians win most suits that go to trial; further, most injuries never become a subject of litigation.

This discussion misses the mark: the real issue is the expense associated with defensive medicine. For instance, as regards the issue of low back pain, an increasing body of research[1] supports the view that X-rays in the absence of a neurologic deficit are mostly unnecessary during the initial care of the patient. Nonetheless, how many of us feel comfortable deferring radiologic studies?

As the provision of medical care becomes more complex it seems to me that it is becoming impossible for juries to really understand the issues involved. Further, the physician always must contend with the possibility of a jury that will simply be sympathetic to the plaintiff regardless of the facts involved.

The only solution to the problem will come when physicians articulate a strong and unambiguous position on a number of points which might include: (1) Having a panel of judges instead of a jury review issues of fact in malpractice cases, (2) adoption of the "English Rule," (3) elimination of contingency fees in malpractice suits, (4) limitations or reasonable regulation of expert testimony to prevent introduction of testimony that is poorly conceived or does not represent opinions that would be considered "reasonable" by the majority of physicians.

F. Andrew Morfesis, MD
Daniel Boone Clinic
Harlan, KY

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Physicians

We are all concerned about health care in this country — the direction it is going, the impact it will have on your patients and families, the type of practice you will have and the paperwork involved. It is past time for us to "unite with one voice" for the future of medicine.

Every physician and physician spouse needs to unite to have an impact on pending legislation — legislation that will ultimately affect each of us and the lives of your patients. The one positive thing that we can do is to join our respective organizations. ***JOIN TODAY*** Join KMA and KMAA. Join KEMPAC. Join the national organization.

PHYSICIANS!!! If you wish to purchase a **gift certificate** for your spouse, you may do so by simply filling out the form below and returning it with a check for $40.00 made payable to KMAA (Kentucky Medical Association Alliance).

Thank you for taking a part in "the future of medicine" by purchasing this gift certificate.

Joyce Clark
KMA Alliance President

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******THANK YOU FOR YOUR MEMBERSHIP******



Joyce Clark

"Did you receive assistance from the student assistance fund while you were in medical school, or an intern or resident?"

AMA-ERF

The American Medical Association Education and Research Fund continues to grow in amount donated and in the assistance it provides to medical students, interns, and residents. Did you receive assistance from the student assistance fund while you were in medical school, or an intern or resident? Maybe you had a personal crisis and needed some help. Do you know where those funds came from? Most probably they came from what is known as AMA-ERF funds.

Each year physicians and physician spouses make donations to the medical school of their choice through AMA-ERF, the American Medical Association Education and Research Fund. Many students, interns, and residents have benefited from our efforts. To quote the spouse of a practicing physician in Eastern Kentucky, "My husband would not have been able to stay in school if he had not received emergency funds from this program." Other stories include receiving emergency money to go home to be by the bedside of a critically ill parent. The stories go on and on of ways this fund has helped individuals during times of crises. The grants and direct financial aid to students can only continue if we continue to support this worthwhile program.

Since 1955, fund-raising for the American Medical Association Education and Research Foundation (AMA-ERF) has been the only philanthropic effort of the AMA Alliance. Over $60,000,000 have been distributed by AMA-ERF to help medical students and schools achieve excellence in education. Since 1990, over $2,000,000 has been raised annually by physician spouses nationally. Kentucky has placed in the top five states nationally over the last 4 years in the amount raised. Boyd county has ranked first or in the top five in per capita funds raised nationally. These are figures that we can all be very proud of.

The Medical School Excellence fund provides grants to medical schools to use where they are most needed. These unrestricted funds can support student programs, research projects, and student attendance at conferences and meetings. It also may be used for equipment, books, and publications.

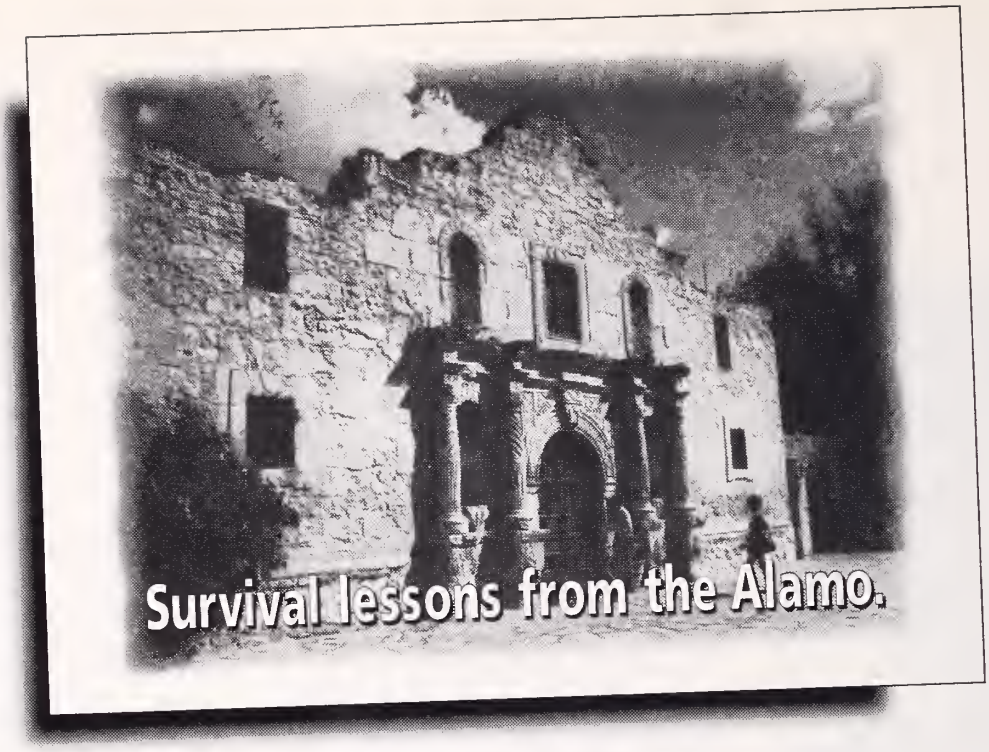
To contribute, make a check payable to AMA-ERF and designate the school of your choice. This can be a school outside of the state if you wish. You may also designate whether you want your money to go to the student assistance fund or the Medical School Excellence fund.

Please mail your check to:
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AMA-ERF Chair
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Help us to continue this program with your contribution.

Joyce Clark

KMA Alliance President



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* The AMA designates the *Interactions* conference for 18 credit hours of Category 1 of the Physician's Recognition Award of the AMA.

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KEMPAC — KMA House of Delegates

The following presentation was made by KEMPAC Chair James Crase, MD, to the 1994 KMA House of Delegates.

Over the years persistent attacks upon political action committees have taken their toll, at least on the state level. With the passage of PAC reform in 1992, Kentucky physicians were eyewitnesses to, and experienced first hand, the dramatic impact it had on medicine's 1994 legislative agenda. Prior to 1992 it was fairly common for KEMPAC to contribute $8,000 to a state Senate or House campaign. The 1992 Kentucky General Assembly limited contributions to state candidates for the House and Senate to $500 per race. Suddenly, legislators had to rely on individuals rather than PACs for campaign dollars. Unfortunately, individual physicians as usual failed to stand in the breech and we paid dearly. This act effectively shut the door to KEMPAC's ability to affect legislative campaigns. AMPAC/KEMPAC was established in the mid 60s to counter labor industry PACs which were pushing for national health insurance. AMPAC/KEMPAC sought out candidates who shared physicians' political and economic philosophies and financially assisted them in their campaigns.

Many of us might be inclined to believe that PACs have a disproportionate influence upon democratic government. While you might think that PACs' roles should be diminished, there is a down side.

Historically, **less than 15%** of Kentucky physicians are members of KEMPAC. This small cadre of physicians pumps approximately $100,000 into Kentucky General Assembly biennial campaigns. KEMPAC was a *big time* player, usually exceeded only by KEA and labor. Secondly, this same small group also dug into their own pockets and personally helped candidates. Coupled with a renewed and revitalized state legislative program in the mid 80s, KMA and KEMPAC in tandem became a driving force in Frankfort.

PAC reforms, along with Boptrot, legislative ethics, and the media's distaste for special interests, poses enormous obstacles for the medical profession. Secondly, the General Assembly remains on course in its drive for independence from the Executive Branch. When the three equal branches of Government, Judicial, Executive, and Legislative, are compared, most observers believe the Legislative Branch has become dominant. Therefore, while the General Assembly grows in power and stature, the mechanisms we have relied upon to participate in determining who sits in that body has been diminished.

The third factor and the one most devastating to medicine is physicians' disinterest in politics, particularly races for the General Assembly. While a few physicians will dig into their pockets to support candidates for Congress, US Senate, or Governor, relatively few physicians contribute to legislative races. The old saying "Washington debates while Frankfort legislates" sure made its presence felt in 1994. KMA has warned us for years that the immediate threat to medicine was in the halls of state government rather than Congress. Obviously we ignored KMA then, and I'm not sure it's sunk in yet. For instance, 100 of 100 House members and 19 of 38 Senators are up for election. Other than a few races, physicians' activity has been nonexistent. The most compelling example of this profession's attitude can be best described by the unbelievable drop in KEMPAC membership this year.

Finally, we must come to grips with the fact that business and agriculture are not on our side. Their only concern is reducing health costs, and as we found out during the 1994 Session, both in Health Reform and Workers' Compensation, doctors were isolated. Employers wanted cuts in medical costs and didn't care how it affected providers. Both the State and many local Chambers of Commerce actively worked for HB 250 and supported even stronger reductions in physician reimbursement under Workers' Compensation.

The forces controlling Frankfort and Washington threatening to turn our medical system upside down are persistent, and like the poor, "will always be with us." The sooner we understand that our foes are formidable, well financed and managed, and are here to stay, the quicker we can go on the offense.

The direction and future activity of KEMPAC, like medicine, is in transformation. While KEMPAC will continue to financially support candidates, most of our resources must be directed toward political education.

1. First, every physician should know how their legislators vote. Full disclosure and reports should be passed along to individual physicians and county medical societies on each legislator's voting record.

2. Second, and most importantly, KEMPAC must begin developing programs to:
   A. Develop training programs and teach physicians and spouses how to run for public office. We need to set a target of 3-5 physicians in each House in the next 5 years. On the local level, we need to find a way to financially support doctors who want to serve but can't abandon their practices for 3 months every other year.
   B. Design programs geared toward teaching physicians and spouses how to conduct political campaigns. In other words, how to be a campaign chairman.
   C. Teach physicians how to get involved in political campaigns. In addition, we need to know what we can — and cannot do with our patient base.
   D. Form a special organization of physicians supporting physician campaigns. There are several legislators we need to target.

We have traditionally kept patients out of our battles. However, House Bill 250, Workers' Compensation reform, provider taxes, Medicaid reductions and various insurance schemes directly affect them — and, they have not been informed about the changes.

Our future is NOW — the cliché "Medicine at the crossroads" is a reality — or more likely — a nightmare in Kentucky. Medicine as we know it, particularly the physician/patient relationship, is threatened. We can complain; we can blame the press, our legal counsel and our lobbyists; we can blame AMA and KMA; we can write letters; we can make phone calls; we can visit Washington and Frankfort; we can even threaten all of the above. Unfortunately doctors — unless you contributed to the campaign, worked for the election or reelection, took the time to get to know the office holder — all your activities may be in vain. Despite the fact that two Senators, one a physician and member of KMA, a top executive in a major Louisville hospital, voted against KMA in the Senate, we still only lost on HB 250 and the tax on a 20-18 vote. One vote more and we could have killed the bill. Here is a prime example of how one vote can affect an issue and points strongly to the fact — if only we had been successful in one more Senatorial District.

WE CAN SURVIVE. We can turn this debacle around. However, to be a force, we must return to grassroots politics and recognize that participation in politics is required CME for doctors. It won't be easy, but I'm confident it can be done.

Medicine has been my life. I am proud to be a physician, and despite all the turmoil, the joy and challenge of patient care is still exciting. Just as our predecessors paved the way for us, we owe the sons and daughters who follow the same wonderful opportunity to practice medicine. The only way we can have an impact upon politics is to jump in — I intend to continue doing just that.

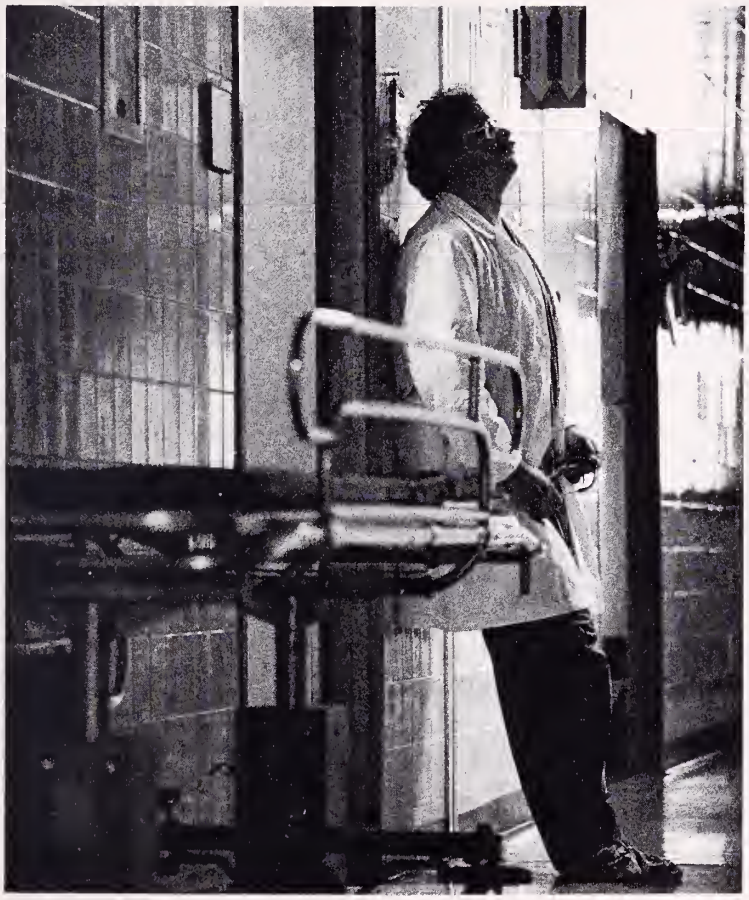


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"Being a patient advocate is what being a physician is all about."

Dr. Kevin Fullin, Cardiologist, Kenosha, Wisconsin,
Member, American Medical Association

Why would a cardiologist get involved in the issue of family violence? Perhaps, because what he saw simply cried out for action.

"Fully a third of all women's injuries coming into our emergency rooms are no accident," says Dr. Fullin.

While others were content to downplay the issue of family violence, Dr. Fullin would not. He petitioned state officials, and through his efforts the first Domestic Violence Advocate Program in his state was created.

"Organized medicine must serve as an advocate for patients," stressed Dr. Fullin.

The American Medical Association (AMA) couldn't agree more. We're committed to focusing physician attention on the issue of family violence.

Become a member of the AMA today.

Members of the AMA are encouraged to join their state, county and specialty societies.

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Physician Recognition Award Recipients

Listed below are KMA member physicians in Kentucky who have earned the AMA's Physician Recognition Award (PRA) from August 1993 through July 1994.

The Award was established by the AMA House of Delegates of the American Medical Association in 1968 "to encourage physician participation in continuing medical education and to recognize physicians who have voluntarily completed programs of continuing medical education." In December 1992, the AMA House of Delegates revised the requirements for the PRA. Physicians now have two choices for PRA certification — a standard certificate and a new PRA certificate "with Special Commendation for Self-Directed Learning." A minimum of 150 credit hours of CME must be earned over a consecutive 3-year period to qualify for the Standard PRA Certificate. Of these 150 hours, at least 60 must be in AMA/PRA Category 1. Ninety hours of education can be

Aguilar-Veza, Corazon	Elizabethtown	Cunningham, James A.	Mount Vernon
Alexander, Keith J.	Lexington	Curd, Philip R.	Sandgap
Allnutt, Charles F.	Covington	Dansby, Karen N.	Ashland
Amerson, Olen D.	Paintsville	Dara, Tanvir M.	London
Amin, Mohammad	Louisville	Daus, Arthur T.	Louisville
Ammon, John D.	Florence	Dickson, Larry G.	Lexington
Archer, Raleigh R.	Lexington	Dowden, William L.	Lexington
Arterberry, Joe F.	Louisville	Einbecker, Mark E.	Lexington
Asher, Christine A.	Trenton	Elliott, Patricia M.	Mayfield
Baldwin, Jonathon	Bowling Green	Faurest, John O. Jr	Louisville
Banks, James W.	Lexington	Ferrell, James L.	Paris
Bardenwerper, Hulburt W.	Louisville	Fetter, James M.	Louisville
Barton, Bruce R.	Louisville	Fitzgerald, Philip D.	Louisville
Bates, Rodney K.	Stanford	Florence, Joseph A.	Hazard
Baxter, Robert F.	Louisville	Frederick, James D.	West Liberty
Bea, Charles E.	Mayfield	Freer, John H.	Hopkinsville
Beasley, John J.	Mayfield	Gaba, Charles R.	Louisville
Bhatraju, Rao S.	Pikeville	Gardner, Alan M.	Lexington
Biagtan, Adelina C.	Louisville	Goodin, Robert R.	Louisville
Bishop, Marvin E.	Winchester	Goodman, Roscoe M.	Williamstown
Blackburn, Dwight L.	Louisville	Graul, William J.	Versailles
Bloom, Steven M.	Louisville	Green, Steven D.	Lancaster
Brennan, James M.	Frankfort	Greenberg, Robert B.	Louisville
Brown, Gregory L.	Louisville	Griffin, Larry P.	Louisville
Burchell, Eugene J.	Edgewood	Griffith, George W.	Mount Vernon
Burgess, Jerald M.	Whitley City	Guiglia, Mary C.	Lexington
Burke, John H.	Lexington	Hafendorfer, Daniel L.	Louisville
Byrd, Robert D.	Owensboro	Hallquist, Allan E.	Edgewood
Campbell, Mark R.	Trenton	Hamilton, Ronald D.	Lexington
Cash, Ralph L.	Princeton	Hay, Herb G.	Madisonville
Cawood, Walter L.	Ashland	Henkel, Terry W.	Louisville
Clark, Dorothy H.	Lexington	Huang, Tsung Y.	Louisville
Clarke, William F.	Lexington	Huszar, Leslie A.	London
Cohen, Norman K.	Louisville	Isaacs, Barbara S.	Louisville
Conrad, Roberta L.	Paducah	Isele, Peter R.	Hopkinsville
Cooper, John G.	Cynthiana	Jahnke, Scott R.	LaGrange
Crawford, Keith H.	Paducah	Jansing, C. William	Owensboro
Crews, James P.	Cave City	Jenkins, Van R.	Lexington
Cromwell, William C.	Hanson	Johnstone, John M.	Richmond
Cummings, Michael L.	Albany	Jones, Shawn C.	Paducah

in Category 2 which includes CME lectures and seminars not designated Category 1; medical teaching; articles, publications, books, and exhibits; and nonsupervised CME such as self-instruction, consultation, patient care review, and self-assessment. Credit hours are based on hour-for-hour participation in a continuing medical education activity with the number of hours rounded to the nearest whole hour. For the new Special Commendation Certificate, the requirements differ from the Standard Certificate in that applicants cannot include reading of medical literature as qualifying for Category 2 and applicants had to obtain a minimum of 20 credit hours of Category 1 and 20 credit hours of Category 2 annually.

We congratulate these physicians who have distinguished themselves and their profession by their commitment to continuing education.

Jurich, Nicholas R.	Prestonsburg
Kelly, Prue W.	Murray
Kelty, Karl C.	Lexington
Koh, Suk-Kyung	Springfield
Kuhn, Wolfgang F.	Louisville
Lee, Robert E.	Louisville
Leedhanachoke, Oon	Pikeville
Lindberg, Robert D.	Louisville
Linger, Judy M.	Georgetown
Litt, Larry M.	Bowling Green
Loeb, Thomas M.	Louisville
Logan, John A. III	Henderson
Longshore, Robert T.	Covington
Lynn, Nicholas R.	Lexington
Maddux, Howard G.	Marion
Mallis, Gary C.	Frankfort
Mangat, Devinder S.	Covington
Martin, Jerry W.	Bowling Green
McCabe, Robert J.	Newport
McClellan, John W.	Henderson
McClure, Larry T.	Ashland
Meyer, David A.	Paducah
Milburn, Carol J. S.	Covington
Milholen, Linda S.	Stanford
Miller, Jon M.	Louisville
Moore, John M.	Lexington
Morgan, Kirk D.	Prospect
Mulligan, John S.	Hopkinsville
Nayak, Irvathur N.	Hazard
Norfleet, Richard H.	Cynthiana
Nunnelley, Preston Jr	Lexington
Offutt, William N.	Lexington
Oropilla, Teresita B.	Louisville
Ortines, Cesar G.	Louisa
Parker, Joseph C. Jr	Louisville
Past, Wallace L. Jr	Campton
Payne, Vaughn W.	Louisville
Perez, Antolin J.	Louisville
Peterson, Hugh R.	Louisville
Potter, Ira B.	Lackey
Potter, Johnny R.	Ashland
Pratt, William D.	London
Proudfoot, Glenn R.	Richmond
Radmanesh, Mark	Somerset
Ravenscraft, Howard L.	Hebron
Rees, Allan H.	Louisville
Reid, Robert L.	Owensboro
Reutman, William E.	Florence
Reynolds, Betsy	Somerset
Riehm, John G.	Louisville
Roeckel, Irene E.	Lexington
Ross, Charles B.	Paducah
Ross, James K.	Ashland
Rouben, David P.	Louisville
Roy, Sunil C.	Whitesburg
Sajadi, Kooros	Lexington
Schiavone, Robert P.	Louisville
Shearer, David A.	Florence
Shearer, Glenn R.	Lexington
Simpson, William G.	Lexington
Smith, Stephen Z.	Louisville
Tate, Kelly S.	Hopkinsville
Taustine, Lloyd R.	Louisville
Travis, Russell L.	Lexington
Tyler, Terry W.	Owensboro
Valera, Erlindo G.	Pikeville
Vasconez, Henry C.	Lexington
Verdi, Gerald D.	Louisville
Villafane, Juan	Louisville
VonderHaar, William P.	Louisville
Warren, Bryan P.	Owensboro
Weiss, Jeffrey A.	Louisville
White David	Prestonsburg
Whitt, John J.	Louisville
Williams, Wayne E.	Mayfield
Witherington, Katherine A.	Louisville
Wittman, William L.	Lexington
Wolfe, Walter M.	Louisville
Womack, Glenn R.	Flemingsburg
Zenger, George H.	Louisville

Statewide CATO Society Meeting

Our 100 retired physicians, some with their spouses, from around Kentucky gathered at the Park Suite of the Hyatt in Louisville to visit with their colleagues and rekindle the fellowship once frequently shared during years of practice. We also extended to the widows of physicians the invitation to join in the activities, and several attended to enliven our conversation.

This meeting was the 5th such gathering scheduled during the Annual Meeting of the Kentucky Medical Association and those in attendance were animated, enthusiastic, and *loud*, which was an indication of the lively spirit of camaraderie felt among us all.

Since many CATO Society members have been out of school for half a century and longer, we departed from our customary practice of an unstructured meeting devoted entirely to animated conversation, including fishing stories occasionally embellished with apocryphal dimensions of weight and length. We invited the Deans of the UK and UL Schools of Medicine to address us briefly about present-day medical education.

A brochure was presented to those in attendance describing the activities of the Medical Foundation, which is the educational and benevolent arm of the Jefferson County Medical Society. Opportunities for interested retired physicians to be of service were also described.

Our colleague Donald H. Mosley, MD, took a few moments to tell us of opportunities for community service at the Hospital Hospitality House in Louisville. This organization provides low-cost temporary accommodations for an out-of-town family when an adult family member is hospitalized in Louisville.

Dean Emery A. Wilson, MD, of UK School of Medicine gave a succinct presentation of the current integrated teaching schedule followed by his faculty in bringing complex basic sciences to the bedside as an integral essential to the teaching of clinical medicine. His remarks were supported and amplified by beautiful slides.

Dean Donald R. Kmetz, MD, of UL School of Medicine took a different approach in telling us about today's medical education. He focused his presentation on the problems of financing today's medical school and its teaching hospital. We were very well apprised of the difficulties encountered when educators must depend in part upon a For-Profit Hospital corporation (operating the teaching hospital of the School of Medicine) as a source of funds to supplement the school's reduced funding from the state budget.

Both of our Deans enlightened us; however, their problems are somewhat different. Changes in the UK curriculum seem to have been effected with fewer difficulties and anxieties than at UL whose teaching hospital is operated by a For-Profit Hospital corporation with goals different from those of educators. Fiscal agents compromise the teaching of clinical medicine in both inpatient and outpatient facilities.

There were 22 attending this meeting from outside Jefferson County, including several eastern counties and a strong group of five from Daviess County where a senior physician group, Agricola Society, meets monthly according to presiding President William J. McManus, MD. They have just begun publishing a quarterly newsletter, *Agricola: The Old Docs*, edited by David A. Orrahood, MD.

CATO Society meetings appear to supply a real need — an opportunity for social contact with former colleagues that has been disrupted by the retirement process. We hope to continue to increase attendance at our CATO Society meetings.

Eugene H. Conner, MD
Louisville, KY



Several af aur most seniar members: L ta R: Clyde H. Fashee, MD, 91 years af age; Isabel Foshee (Mrs Clyde H.) and Jesse Bell, MD, 90 years of age, all fram Jeffersan Caunty.

Ackermann, Kurt, MD
Adkins, Flora
Alberhasky, Robert, MD
Alberhasky, Hilda
Alfano, Frank, MD
Barlow, Fred, MD
Bell, Jesse, MD
Bennett, W. Neal, "Bud," MD
Berg, Harold, MD
Berg, Pearl
Bernhard, C. Melvin, MD
Bradley, Herbert, MD
Canfield, Bourbon, MD
Canfield, Carlita
Christian, E. G., MD
Christopherson, William, MD
Clark, Orville, MD
Coe, Walter, MD
Coe, Billie
Conner, Eugene, MD
Crabtree, Carson, MD
Crabtree, Lois
Crawford, Kenneth, MD
Davis, James, MD
Davis, Barbara
DeMunbrun, Donne, MD
DeMunbrun, T. W., MD
Denham, Ralph, MD
Dickinson, Lewis, MD *(Glasgow)*
Doyle, George, MD
Durham, William, MD
Dyer, Robert, MD
Farnsley, Wesley, MD
Foshee, Clyde, MD
Foshee, Isabel
Fowler, Merle, Jr, MD *(Paducah)*
Gaines, Frank, MD
Griffin, David, MD
Griffin, Yvonne
Hamilton, Wm. Bruce, MD
Hemmer, John, MD
Hemmer, Mary Kay
Hopkins, William, MD
Hopkins, Loetta
Hume, Walter, MD
Jenkins, Douglas, MD *(Richmond)*
Johnson, Ann, MD *(Owensboro)*
Kelty, Karl, MD *(Lexington)*
Kelty, Merle *(Lexington)*
Kotcamp, Wayne, MD
Lewis, David, MD *(Elizabethtown)*
Lewis, Leslie *(Elizabethtown)*
Lykins, Robert, MD
Lykins, Elise
Marshall, Tom, MD
Martin, Roy, MD
Martin, Iris
McClendon, Robert, MD
McWhorter, H. B., MD *(Ashland)*
McWhorter, Roberta *(Ashland)*
Moore, Condit, MD
Moore, Loran, MD *(Owensboro)*
Moorhatch, John, MD
Mosley, Don, MD
Nash, William, MD *(Naples, FL)*
Norvell, Wyatt, MD *(New Castle)*
Norvell, Dorothy *(New Castle)*
Oliver, Earl, MD *(Scottsville)*
Orrahood, David, MD *(Owensboro)*
Parker, James, MD
Pedigo, George, Jr, MD
Phillips, R. J., MD *(Gilbertsville)*
Popham, Bernard, MD *(Brandenburg)*
Quaife, Clarence, D
Ransdell, Herbert, MD
Ransdell, Nellie
Reid, Ben, Sr, MD
Roser, Charles, MD
Roser, Katie
Rumage, William, MD
Schafer, George, MD
Scheen, S. Randolph, Jr, MD
Schupbach, Harold, MD
Schupbach, Berta
Shrader, Edward, MD
Smith, John, MD
Smith, Orson, MD
Stevens, Elliott, MD *(Owensboro)*
Stiles, Joseph, MD *(Owensboro)*
Tanner, George, MD *(Cynthiana)*
Tobin, Daniel, MD
Wagner, Alfred, MD
Wagner, Juanita
Weakley, Lolita, MD
Weakley, Sam, MD
Weldon, Thomas, MD *(Warsaw)*
Kmetz, Donald R., MD *(Speaker)*
Wilson, Emery A., MD *(Speaker)*
Lomond, Demerese *(JCMS Staff)*
Miller, Lana *(JCMS Staff)*



Two old friends: L to R: Bernord I. Pophom, MD, from Brondenburg, Meode County, ond Rolph M. Denhom, MD, from Jefferson County.



Western Kentucky was well represented: L to R: Ann Hordin Johnson, MD; Loron P. Moore, MD, and Joseph C. Stiles, MD, oll from Owensboro, Doviess County.



Friendships renewed: L to R: Earl Oliver, MD, from Scottsville, Allen County; Wolter S. Coe, MD, ond Billie Coe (Mrs Wolter), from Jefferson County, ond Lewis Dickinson, MD, from Glosgow, Borren County.

PEOPLE

Milton F. Miller, MD, Louisville, has been inducted as a Fellow of the American College of Physicians.

The Jewish Hospital Medical Staff installed the following new leaders at their annual meeting: **Stephen J. Sweitzer, MD,** president; **David H. Goldstein, MD,** president-elect; **David M. Holland, MD,** secretary; **B. Frank Parker, MD,** and **A. David Slater, MD,** at-large members.

The American Academy of Ophthalmology announced that **Roland H. Myers, MD,** is a 1994 Honor Award recipient. Dr Myers is in private practice in Paducah, KY.

Honor awards recognize individuals who have made a significant contribution to ophthalmology through presentations at the Academy annual meeting, and for service on Academy committees.

UPDATES

JCMS Outreach Program Selected for Robert Wood Johnson Foundation Grant

The Robert Wood Johnson Foundation recently announced that it has awarded $2.2 million to 22 private physicians' groups in 21 communities around the country. The program — *REACH OUT: Physicians' Initiative to Expand Care to Underserved Americans* — is a major national effort to mobilize private physicians to improve access to care for the underserved.

A Jefferson County Medical Society grant application, submitted on behalf of its Outreach Program — The Healing Place, a Louisville shelter where doctors volunteer their services to the homeless — received a $97,930 planning grant "to develop new approaches for delivering medical care to people who currently have difficulty obtaining it." The RWJ Foundation cited The Healing Place's plan to "increase private physician participation in caring for the homeless, hungry and addicted." The Healing Place plans to increase access to and use of primary care facilities and expand the base of physician volunteers serving clinics.

Supervising the project are Project Director **Mary Ann Catherine Henry, MD;** Addictionologist **Burns Brady, MD;** and The Healing Place President **Will W. Ward, MD.**

Health Care of Rural Elderly

A report from the UK Medical Center states that providing health care to the elderly and to rural areas in Kentucky is the focus of the Rural Health Interdisciplinary Training Project that began October 1, 1994.

The University of Kentucky College of Allied Health Professions, Sanders-Brown Center on Aging, and the St. Claire Medical Center in Morehead have received a 3-year grant for $580,603 from the US Department of Health and Human Services to initiate the Rural Health Interdisciplinary Training Project.

The UK Medical Center also has a history of commitment to addressing the health care needs of the rural population and specifically in the past few years has developed the Area Health Education Center Program and played a major role in securing passage of the Omnibus Health Care Act which has a far-reaching impact on rural health care in Kentucky.

The goals of the Rural Health Interdisciplinary Training Projects are:

— establish interdisciplinary geriatric assessment primary care clinics in rural Kentucky
— provide training sites for students while working on an interdisciplinary geriatrics team
— enhance research in rural areas
— increase the recruitment and retention of health care providers in rural areas.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Fayette

John L. Buker, MD — D
1401 Harrodsburg Rd #C-415, Lexington 40504
1982, Medical Col of Ohio

James W. Holsinger, MD — C
4705 Waterside Ct, Lexington 40513
1964, Duke U

Joyce H. Holz, MD — OBG
2620 Wilhite Dr, Lexington 40503
1987, U of Texas

John F. Jansen, MD — PTH
290 Big Run Rd, Lexington 40503
1988, U of Kentucky

Gary K. Margolies, MD — IM
231 Gold Keene Pl, Lexington 40509
1987, U of California

Charles G. Ray, MD — S
1760 Nicholasville Rd #301, Lexington 40503
1989, U of Kentucky

Lynda P. Sanders, MD — PD
1780 Nicholasville Rd #201, Lexington 40503
1987, Bowman Gray

Stella R. Staley, MD — IM
321 Crillon Dr, Lexington 40503
1985, U of Kentucky

Franklin

Mark R. Jones, MD — R
2 Physicians Park Dr, Frankfort 40601
1986, Medical Col of Georgia

Henderson

Jacob M. O'Neill, MD — ORS
1725 N Green St #100, Henderson 42420
1982, U of Southern California

Jefferson

Randall E. Draper, MD — P
14202 Lake Forest Dr, Louisville 40245
1985, U of Utah
Fanette M. Thornhill-Scott, MD — PD
3 Audubon Plaza Dr, Louisville 40217
1983, Meharry Medical Col

Logan

Mary C. Meyers, MD —PD
101 W Second St, Russellville 42276
1975, Columbia U
Robert H. Meyers, MD — ORS
101 W Second St, Russellville 42276
1974, U of Munich

Madison

Neil J. Klemek, MD — FP
PO Box 427, Berea 40403
1979, U of Guadalajara

Nelson

Stanley D. Allen, MD — ORS
P O Box 728, Bardstown 40004
1978, U of Texas

Warren

Allen O. Powell, MD — R
250 Park St, Bowling Green 42101
1988, Duke U

In-Training

Fayette

Todd R. Cheever, MD — P
Timothy J. Dalton, MD — IM
Richard I. Williams, MD — ORS

DEATHS

Frederick A. Scott, MD
Madisonville
1911-1994

Frederick A. Scott, MD, a retired anesthesiologist, died August 7, 1994. Dr Scott graduated from the University of Louisville School of Medicine in 1938 and was a life member of KMA.

Houston W. Shaw, MD
Louisville
1910-1994

Houston W. Shaw, MD, a retired surgeon, died September 3, 1994. A 1933 graduate of the University of Cincinnati College of Medicine, Dr Shaw was a life member of KMA.

Richard E. Mardis, MD
Campbellsville
1919-1994

Richard E. Mardis, MD, a retired internist, died September 4, 1994. Dr Mardis was a 1944 graduate of the University of Louisville School of Medicine and a life member of KMA.

TO HELP OTHERS WE MUST HELP EACH OTHER

As physicians, we are responsible for the health and well-being of those around us. When a physician develops problems that impair his or her ability to carry out professional responsibilities, it's up to us to help.

The goal of the impaired physicians program of the Kentucky Medical Association is to assist physicians and their families who are demonstrating problems associated with the inappropriate use of alcohol and/or drugs, emotional and mental disability, or the aging process.

The committee supports a policy of early identification, by self, colleagues, or others, and active intervention to bring prompt assistance to the physician while ensuring the welfare of his or her patients. The policy is designed to ensure referral to acceptable treatment resources with the aim of full rehabilitation.

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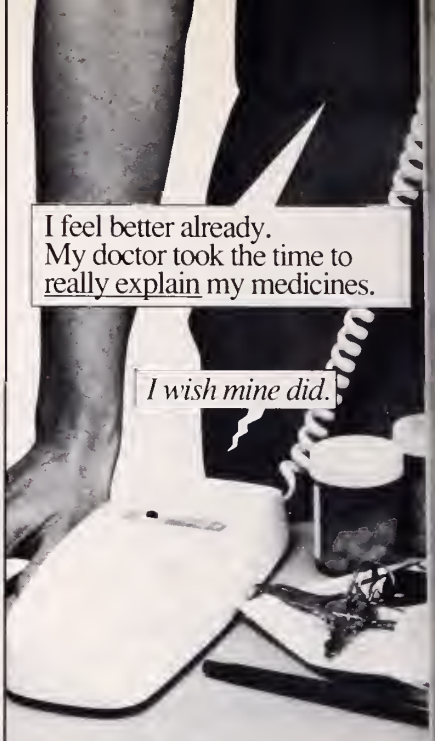
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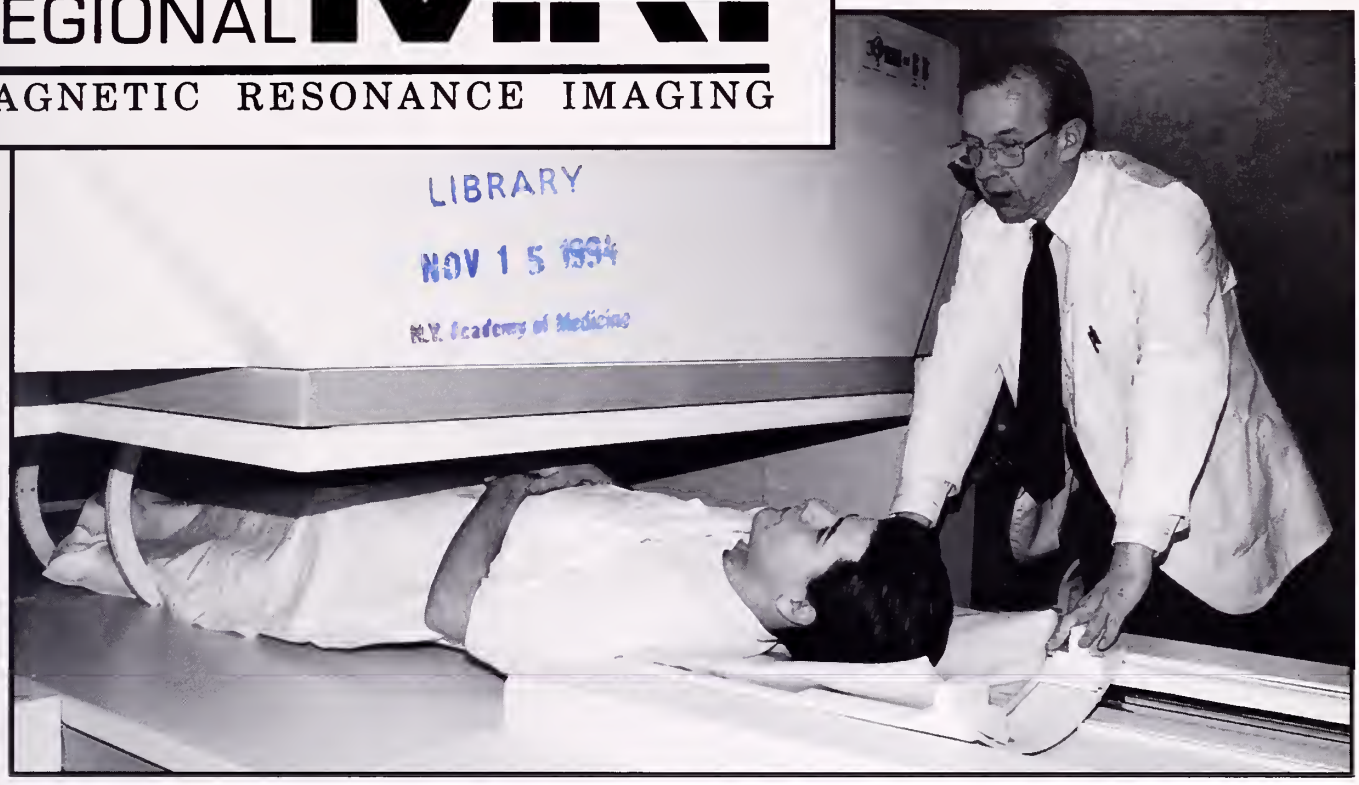
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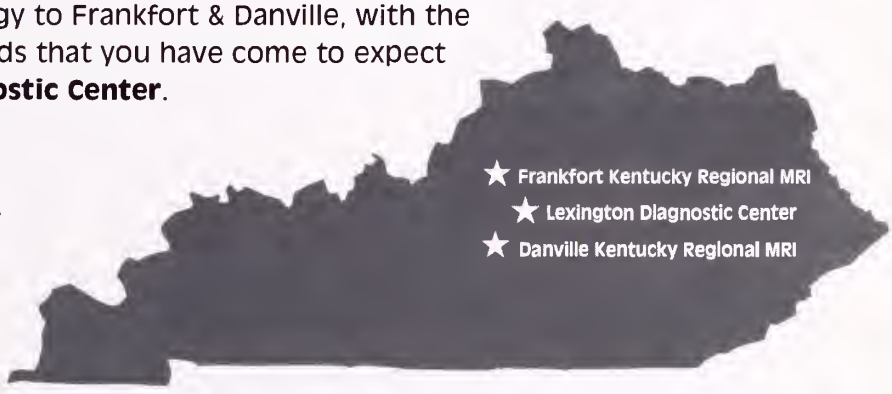
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JOURNAL OF THE

KENTUCKY MEDICAL

ASSOCIATION

VOLUME 92, NUMBER 12 DECEMBER 1994



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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Second-class postage paid at Louisville, KY and additional offices. Yearly subscription rates: $25 domestic; $30 foreign. Single issues $3 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association*, 301 N Hurstbourne Pkwy, Suite 200, Louisville, KY 40222-8512. EDITORIAL AND ADVERTISING: Telephone 502/426-6200.

Listed in Index Medicus. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

National advertising representative: State Medical Journal Advertising Bureau, Inc, 11437 W 106th St, Overland Park, KS 66214, phone 800/788-2360.

The *Journal*, its editors, and the Kentucky Medical Association do not assume responsibility for the opinions and statements of its contributors and advertisers. The *Journal* reserves the right to make the final decision on all content and advertisements.

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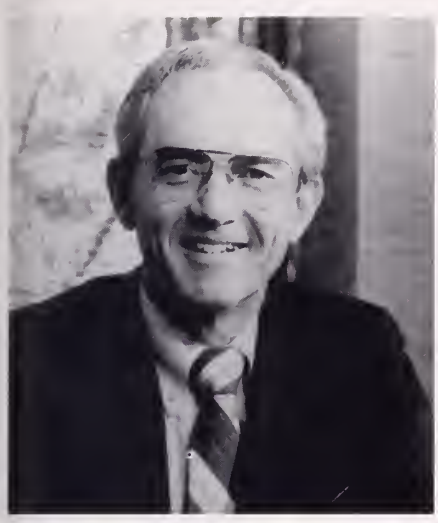
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Robert R. Goodin, MD

A Time to Care

"This caring is what our patients need now more than ever, as they are pushed, shoved, and driven into various health care systems, many with little choice of what physician they may see or where they must go to receive their health care."

During this holiday season I hope you will permit me to wax a little philosophical. These past few years have been turbulent and downright distressing for physicians. What with health system reform efforts at state and national levels along with marked changes in health care delivery systems (managed care, consolidation, integration, mergers), it seems we are being attacked from all sides. The politicians and media would have us believe that we are greedy, self serving, and uncaring, and they claim that the image of our profession is in a sharp decline. I don't accept any of these unfounded claims, and we all know that our primary commitment is to our patients and this commitment has not faltered.

Let me remind us of several reasons why we must continue to stand up proudly for our honorable profession:

- Since its inception in 1985, Kentucky physicians have provided 250,000 free office visits to patients through the Kentucky Physicians Care Program.
- The average US physician provides 150 hours (3 weeks' work for most people, nearer to 2 weeks' work for physicians) of free patient care per year.
- The Healing Place for homeless men operated by Jefferson County physicians and their spouses is a national model for community service by the medical profession.
- Numerous other community activities by physicians involve free health care, health exams, school health, and other health clinics.
- Despite reports to the contrary, physicians are generous in giving to charitable organizations and to community causes.
- Many physicians and their families serve leadership roles in community organizations, civic clubs, school boards, and in public elected office.

These activities do continue, as they must, even as physicians feel increasingly helpless at the loss of autonomy and loss of freedom to practice medicine without intrusion, as our patients deserve. With the massive push to control health care costs, we see a fight for control of health care by government, hospitals, insurance companies, entrepreneurs, and managed care organizations. We are now even seeing turf battles among physician groups such as hospital medical staff, and primary care vs non-primary care specialists. Let us not miss this potential opportunity in fact for physicians to regain control of our profession and the health care system, simply because of petty turf quarrels. We can and we must for the sake of our patients unify as a profession and exert the inordinate power that unity can wield.

One of the most important things we can do is to return to our core

values. We must recall that idealism we had in medical school and residency. We wanted to care for patients, and we wanted patients to know that we care. This calling, in which we place our patients' best interest above all else, is what all physicians have in common regardless of less important differences that we may have. This caring is what our patients need now more than ever, as they are pushed, shoved, and driven into various health care systems, many with little choice of what physician they may see or where they must go to receive their health care. Do not think for a moment that these other players in the health care delivery system (hospitals, insurance companies, managed care organizations, etc) place caring as a top priority. Economic concerns may well, in fact, jeopardize quality patient care unless we intervene for our patients.

This sense of caring is exactly why we continue to provide many voluntary hours to patient care. If we can unite ourselves, based on the core values that led us into medicine, then we can be a very formidable force in protecting our patients and our profession during these trying years. I am convinced that taking the high road will always win out over fanning fears and promoting isolationism in the profession. Do we want to be people who watch things happen, people who wonder what happened, or people who make things happen? We can make things happen if we recommit the energy and intellect that we committed during those tough medical school and post-graduate training years.

In 1959, during my University of Louisville School of Medicine application interview with Dr Arch Cole, he referred to my youth — age 19 — and limited liberal arts education and asked, "Do you plan to care for people or horses?" My scared to death response was "people I hope." I am happy to say my answer was correct. I do, in fact, care for people, and I believe that all physicians do.

So in this season for reflection, let us all remember to be grateful for the honor and indeed privilege society has granted us to practice this proud profession. Let us continue to care for our patients, our community, and our profession.

Robert R. Goodin, MD
KMA President

In Memoriam

That best portion of a good person's life, his little, nameless, unremembered acts of kindness and of love.

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Incidence of *Haemophilus influenzae* Type b Disease in Kentucky

Relationship to Immunization, 1988 Through 1993

Barry J. Meade, MS, DVM; Reginald F. Finger, MD, MPH; Daniel M. Sosin, MD, MPH

Dr Meade is a veterinarian with the US Department of Agriculture. At the time of submission of this article, he worked as epidemiologist with the Kentucky Department for Health Services. Dr Finger is Director of the Division of Epidemiology, Kentucky Department for Health Services. Dr Sosin is a Medical Epidemiologist in the National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Until recently, *Haemophilus influenzae* type b (Hib) was recognized as a leading cause of invasive bacterial infection among infants and young children.[1] Before the introduction of effective vaccines, an estimated 12,000 cases of invasive Hib disease occurred annually among children <5 years of age.[2] In Kentucky, 87% of all reported cases from 1986 through 1990 occurred in children <5 years of age.[3]

H influenzae is a small gram-negative coccobacillus with both encapsulated and nonencapsulated strains. Almost all cases of serious, invasive infection among children are due to the type b encapsulated strain. The organism usually causes sporadic cases, but may be responsible for outbreaks, particularly in day care centers. The most serious systemic diseases commonly associated with Hib include meningitis, acute epiglottitis, pneumonia, septicemia, cellulitis, and septic arthritis.[4]

Since 1985, six *H influenzae* vaccines have been licensed for use in the United States. Guidelines for vaccine usage were issued by the US Public Health Service Advisory Committee on Immunization Practices (ACIP) and by the American Academy of Pediatrics. After the introduction of these vaccines, the number of cases reported nationally of Hib decreased.[1, 5-7]

A simplified chronology of licensure and first use for these vaccines in Kentucky is included in this report (Table 1). The first Hib vaccine (PRP), licensed in April 1985, was composed of capsular polysaccharide, a virulence factor for the organism.[8] Preliminary studies indicated that the vaccine provided protection to children ≥24 months of age.[9] Studies published after the release of the vaccine indicated varied estimates of vaccine efficacy ranging from <0% to 88%.[10, 11] This apparent lack of effectiveness was supported by additional evidence that indicated limited immunogenicity of the vaccine and no significant reduction of disease incidence in some populations after vaccine licensure.[5] On the basis of this information, Kentucky discontinued distribution of this vaccine in June 1988.[12]

In December 1987, an improved polysaccharide vaccine conjugated with diphtheria toxoid (PRP-D) was licensed for use in children ≥18 months of age.[13] As with the earlier PRP vaccine, PRP-D was shown to be safe, but because of budget constraints within the Kentucky Immunization Program, PRP-D was not distributed in 1988. Following the award of a federal contract for the purchase of PRP-D and the subsequent availability of the vaccine at lower prices, the Immunization Program began distributing PRP-D in February 1989.[12] On the basis of recommendations from the ACIP, the use of PRP-D was recommended for children ≥15 months of age in April 1990.[14]

Two newer Hib conjugate vaccines, PRP-OMP and HbOC, were licensed for use in October and December 1990.[15] Although these vaccines have different chemical compositions, each is considered effective for use among infants in a three-dose (PRP-OMP) or a four-dose (HbOC) series, beginning at 2 months of age. The HbOC

Table 1. Simplified chronology of *Haemophilus influenzae* Type b vaccine licensure in the United States and use in Kentucky

Date of licensure	Vaccine type	Recommended age (months) at first dose	Date first used in Kentucky
Apr 1985	PRP*	24	Jun 1985
Dec 1987	Conjugate	18	Feb 1989
Apr 1990	Conjugate	15	Apr 1990
Oct 1990	Conjugate	2	Dec 1990

*Vaccine derived from polyribosylribitol phosphate capsule.

type Hib vaccine was initially purchased by the Immunization Program in December 1990.[16]

On March 30, 1993, the Food and Drug Administration (FDA) approved two new Hib vaccines for use among children. PRP-T, a *Haemophilus* b vaccine conjugated to tetanus toxoid, provides protection against *H influenzae* only. The other vaccine, DTP/HbOC, is formulated with three other antigens to provide protection against diphtheria, tetanus, pertussis, and Hib disease.[17] The ACIP recommendations regarding these vaccines were published in November 1993. The Kentucky Immunization Program has not purchased or distributed PRP-T, and did not purchase DTP/Hboc until February 1994. Because these products are relatively new and a minimal number of doses were administered in the private sector in Kentucky, their contribution to the overall reduction in invasive Hib was not considered in this study.

The purpose of this study was to evaluate the incidence of reported Hib in Kentucky from 1986 through 1992 and the correlation between reported cases and the vaccines which were used during those years. In addition, cases of invasive Hib disease reported during 1992 and the first 8 months of 1993 were reviewed to determine the correlation between disease and immunization status.

Methods

Source of Data

Reports of invasive Hib were collected from the reportable disease registry in the Surveillance Branch, Division of Epidemiology, Kentucky Department for Health Services. These cases have been collected continuously since 1977 and reported weekly to the Centers for Disease Control and Prevention (CDC) as part of the National Bacterial Meningitis Reporting System. It was not until January 1986, however, that the disease registry became computerized. Before 1986, data from cases of *H influenzae* are less reliable. Consequently, only cases of *H influenzae* with date of onset later than 1985 were included in this study.

We used the CDC case definition for invasive Hib: any report of meningitis, bacteremia, epiglottitis, or pneumonia among patients with a positive culture of *H influenzae* obtained from a normally sterile site. Reports of otitis media, tracheitis, and conjunctivitis, or non-sterile cultures such as sputum or nasopharyngeal aspirates were not included as cases in the analysis.

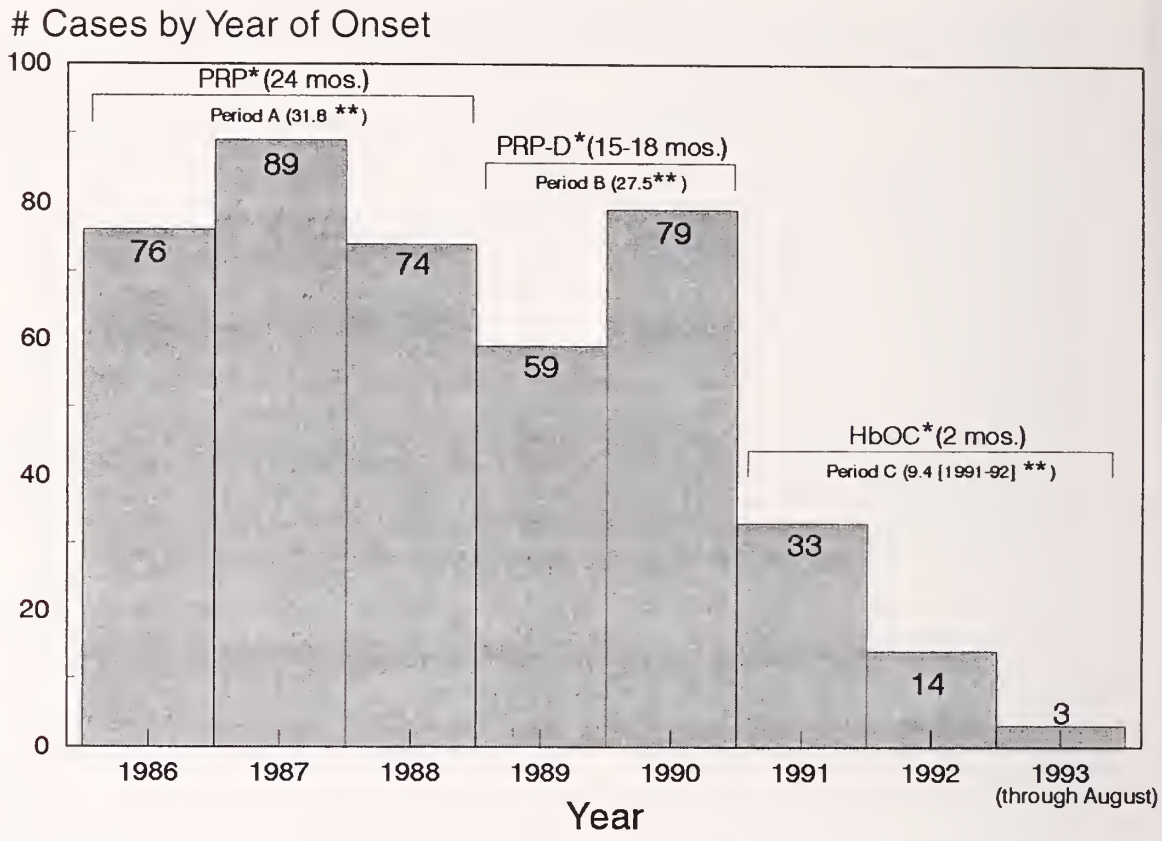
Categorization of Case-Patients by Time Period

To evaluate the impact of vaccine type on the reported incidence of Hib, cases were categorized by year of onset according to the predominant vaccine in use at that time. During the period 1986-88, PRP was the only vaccine available; case-patients with onset of illness from 1986 through 1988 were assigned to time period A. During the period 1989 through 1990, PRP-D conjugate vaccine was available for use among children ≥15 months of age. Case-patients with onset of illness during these years were included in time period B. During 1991 through 1992, HbOC became available for use among children ≥2 months of age. Case-patients with onsets during the period 1991-92 were assigned to time period C. Incidence rates were computed for each time period and for individual age strata within each time period.

We chose this method of partitioning cases into time periods based on the type of vaccine in use because direct vaccination coverage data was lacking. We assumed that the population immunity conferred during these time periods would be directly attributable to the type of vaccine in use. This is appropriate because the lag time between vaccine effect and onset of disease would be minimal, and because most cases during a specific time period occur among the youngest vaccine-eligible children.

Immunization Status

Reports for persons who developed Hib during the 1992-93 reporting period were reviewed to determine the date of symptom onset, whether any Hib vaccinations were administered, and age at vaccination. Cases were assigned to a reporting period based on the date of receipt of the initial report by the Surveillance and Investigation Branch. Classifying Hib cases by the year in which their reports are received is consistent with classifying other notifiable diseases and may include cases whose date of symptom onset was during the previous calendar year. Age at vaccination was defined as the interval between date of birth and date of administration of a dose of Hib vaccine. Determination of case-patients' up-to-date status (UTD) for Hib vaccine was made based on the ACIP recommendations of vaccine administration at 2, 4, 6, and 15 months of age. Because HbOC conjugate vaccine was the only Hib vaccine distributed by the Kentucky Immunization Program during this period, and since the Immunization Program is the primary distributor of



* Refers to the vaccine supplied during designated years by the State Immunization Program.
** Incidence per 100,000 population.

Fig 1 — Reported cases of Haemophilus influenzae, by year of onset and vaccine group, children ≤5 years of age, Kentucky, 1986-1993.

childhood vaccine in the state, the immunization schedule was based on recommendations for this conjugate vaccine. A grace period was allowed for each dose of vaccine so that persons were considered UTD if they received each dose of vaccine within 2 months of the recommended schedule. Therefore, case-patients were UTD if they had received the first dose by 4 months of age, the second dose by 6 months of age, the third dose by 8 months of age, and the fourth dose by 17 months of age. On the basis of ACIP recommendations, children 12-14 months of age were considered UTD if they received one dose of vaccine before 12 months of age and a booster as soon as possible at an interval not less than 2 months after the previous dose. Children >15 months of age were considered UTD if they received one dose of any of the three conjugate vaccines licensed for use among this age group.

Statistical Analysis

Age-specific incidence rates were calculated based on reported cases of Hib by year of onset and on the 1990 Kentucky census data.

A Mantel-Haenszel χ^2 test for trend was calculated using EPI-INFO version 5.0.[18] Differences were considered significant for p values <.05.

Results

A total of 473 cases of *H influenzae* were reported from 1986 through 1992. Of these cases, 89% (424/473) occurred among children ≤5 years of age. During the period 1986-90, a mean of 75 cases were reported in this age group, whereas for 1991 and 1992, only 33 and 14 cases, respectively, met the case definition (Fig 1).

A small reduction in incidence of Hib was initially noted after the introduction of PRP-D vac-

cine in 1989 (31.8 vs 27.5) (Fig 1). Only after the introduction of the newer conjugate vaccine HbOC in 1991 for use among children ≥2 months of age was a large reduction in disease documented.

Since 1986, an age-specific incidence rate of 53.4 cases of Hib per 100,000 occurred among children during their second year of life (Fig 2). This age group had the highest incidence and accounted for 46% (198/424) of cases among children ≤5 years of age. When combined with the number of cases in children ≤1 year of age, 70% (299/424) of all cases could be accounted for in children <2 years of age. These two age groups represent the children who are at highest risk for disease. The use of vaccine in these age groups would have the greatest impact.

The age-specific incidence and risk ratios for *H influenzae* among children 0-5 years of age by type of vaccine are presented in this document (Table 2). A significant reduction in Hib ($p < .001$) followed the introduction of the conjugate vaccines. Overall, the risk for developing Hib after conjugate vaccine was approved for children ≥2 months of age decreased 70% compared with the period when PRP was used. In particular, for children <2 years of age, the risk of Hib decreased 68%.

Twenty-one cases of invasive Hib were reported during the 1992-93 reporting period. Nineteen case-patients were <24 months of age at date of onset, and only eight of the 21 case-patients had received any vaccine. Six of the 21 cases were considered UTD: one 2-month-old child who developed Hib before he was eligible for vaccine; four children who received one dose

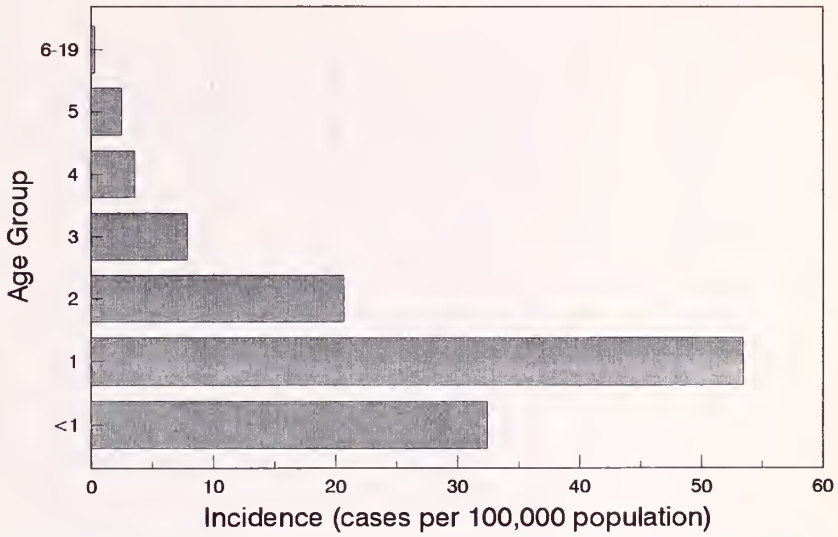


Fig 2 — Age-specific incidence rate* Haemophilus influenzae *Kentucky, 1986-1992.

of vaccine, three by 4 months of age, and one at 18 months of age; and a sixth child who had two doses of vaccine by 5 months of age. No case-patients received three or more doses of Hib vaccine.

The delay or absence of vaccination among the 15, 1992-93 case-patients who were not UTD is attributable to provider- or parental-type barriers. Provider barriers included seven missed opportunities for administration of vaccine while the child was present for other services: five for simultaneous administration of HbOC along with other vaccines and two during well-child/W.I.C. visits. One child with leukemia was inappropriately advised to forego the vaccine. The seven case-pa-

Table 2. Age-specific incidence rate* and risk ratios for *Hoemophilus influenzae*, children ≤5 yeors of age by vaccine in use,** Kentucky, 1986-1992

Vaccine in Use	Age Stratum <1 Rate	<1 (Risk Rotio)	1 Rate	1 (Risk Ratio)	2-5 Rate	2-5 (Risk Ratio)	Ages 0-5[a]	(Risk Ratio)
PRP (24 mos)	40.8	(ref.)	75.6	(ref.)	10.5	(ref.)	31.8	(ref.)
PRP-D (15-18 mos)	44.3	(1.08)	52.9	(0.70)	10.4	(0.99)	27.5	(0.87)
HbOC (2 mos)	9.1	(0.22)	20.8	(0.28)	4.1	(0.39)	9.4	(0.29)

[a] Chi-square for trend (oll children <5 years of age) = 58.7
1 df
$p < .001$
* Per 100,000 populotion.
** Refers to voccine supplied by the State Immunizotion Program and recommended age at first dose.

tients with parental barriers to vaccination included three children who received one dose of vaccine but failed to return for additional doses, one child with a religious exemption, and three children who never presented for any health services.

Follow-up information was obtained from the health-care provider for the child who developed invasive Hib after two doses of HbOC. The case-patient's past medical history, immunization schedule, and Hib serology following onset of illness were provided. The case-patient was of Cambodian descent whose twin sibling was stillborn. His medical history before the onset of Hib was unremarkable and consisted of three visits for well-child exams and vaccinations, including HbOC vaccine at 8 and 19 weeks of age. He developed otitis media at 20 weeks of age, which progressed rapidly into meningitis. Cultures obtained from both cerebrospinal fluid and blood yielded growth of *H influenzae*. Serologic titers drawn on days 4, 35, and 75 after onset of illness revealed a less than adequate immunologic response, even though he had received a HbOC booster on day 58 post infection. This is the only documented case of invasive Hib in Kentucky that occurred after administration of ≥2 doses of HbOC.

Discussion

Analysis of routine surveillance data suggests that a temporal association exists between the documented decrease in the reported cases of invasive Hib and the use of the newer conjugate vaccine among infants. This finding is consistent with national trends and implies that the use of vaccine is having a positive impact on the occurrence of Hib disease in Kentucky. For children ≤5 years of age, the use of HbOC vaccine appears to have contributed to more than a 70% decrease in the occurrence of disease between the periods 1986-88 and 1991-92.

Although a decline in disease has been associated with the use of vaccine, some researchers have suggested that factors other than vaccine may contribute to a decline in Hib.[1, 6, 7] Changes in the case reporting of Hib could be due to either a failure of the surveillance system to identify cases, a change in diagnostic or therapeutic practices that has altered disease outcome, or a change in herd immunity. It is unlikely that during our study period the surveillance system became less sensitive in identifying cases of Hib. During the same period, the number of reports of meningococcal meningitis, a similar disease that is reported through the same system, increased. Furthermore, no known substantial change in medical practices has occurred that could account for the observed decreases in Hib disease. Recently, Hib conjugate vaccine has been reported to lower the rate of Hib nasopharyngeal colonization and thus limit transmission from older children to infants and younger siblings.[6, 7] This could result in the lowering of incidence rates among children too young to receive vaccine by decreasing their potential for exposure. However, a decline in incidence of Hib was not noted among children ≤1 year of age when conjugate vaccine was first introduced in Kentucky (1989-90). Instead, incidence declined in this age group only after children ≥2 months of age became eligible to receive vaccine. After the introduction of newer conjugate vaccines in 1991, a decline in Hib was also observed among children ≥1 year of age. Whether these changes in herd immunity are related to expanded vaccine coverage or to improved efficacy of newer conjugate vaccines cannot be determined without accurate vaccination coverage data.

The effectiveness of Hib conjugate vaccine was supported by the low incidence of disease in persons who had received two or more doses of vaccine. Studies have shown that conjugate vaccines produce markedly different immunologic response among different ethnic groups.[8] The case in a patient who had been administered two doses of vaccine may have been attributable to some host factor that limited the immune response.

Although the prevention of Hib among children who complete a recommended vaccine schedule is well documented, the barriers to vaccination and the consequences of a delayed or missing vaccination are less often noted. Only eight case-patients had received any vaccine prior to the onset of illness, with a majority (62%) of the case-patients being unprotected. Many of the reasons for failure to vaccinate can be attributed to provider-level impediments that are potentially the easiest to correct. As with other immunizations, we must try to remove every possible barrier, both parental and provider, so that every child is protected.

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(Required by 39 U.S.C. 3685)

1A Title of Publication	1B PUBLICATION NO	2 Date of Filing
Journal of the Kentucky Medical Association	2 8 0 - 7 0 0	9/30/94
3 Frequency of Issue: Monthly	3A No. of Issues Published Annually: 12	3B Annual Subscription Price: $25.00

4 Complete Mailing Address of Known Office of Publication (Street, City, County, State and ZIP+4 Code) (Not printers)
301 N. Hurstbourne Pkwy, Suite 200, Louisville, KY 40222-8512

5 Complete Mailing Address of the Headquarters or General Business Offices of the Publisher (Not printer)
301 N. Hurstbourne Pkwy, Suite 200, Louisville, KY 40222-8512

6 Full Names and Complete Mailing Address of Publisher, Editor, and Managing Editor (This item MUST NOT be blank)
Publisher (Name and Complete Mailing Address)
Board of Trustees, Kentucky Medical Association
301 N. Hurstbourne Pkwy, Suite 200, Louisville, KY 40222-8512
Editor (Name and Complete Mailing Address)
A. Evan Overstreet, MD, 301 N. Hurstbourne Pkwy, Suite 200, Louisville, KY 40222-8512
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Full Name	Complete Mailing Address
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10 Extent and Nature of Circulation (See instructions on reverse side)	Average No. Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
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AIR FORCE

Be Reassured

One of the consequences of becoming passionately engaged in any endeavor is a loss of perspective. In the current furor over governmental reform initiatives, insurance reform, cost containment, access to care, and other issues, we may wonder why any sane individual would consider entering our profession. Yet, nationally, and in this state, medical school admissions are up significantly and the academic caliber of students is as impressive as ever. How could this be?

We should be reassured to find that students still wish to pursue medicine as a profession for most of the same reasons that motivated us. They find themselves fascinated by the intricacies of living organisms and the complexities of their interrelationships. They have found disciplined expression for their scientific curiosity in their first research pursuits. They have been touched by their encounters with the less fortunate, the needy, the sick, and the dying. They are motivated by the desire to cultivate a personal and professional life rich in service to their communities. They seek security, respect, and personal satisfaction, and they find medicine as their preferred venue to achieve all of these things.

Many will apply to medical school several times before entering. Many will leave successful careers to begin a daunting 8 years or more of training. Almost all will forego financial security for the foreseeable future by accruing massive debts to accommodate their years of training. Yet, they will all still put on their white coats, fill their pockets with stethoscopes and the *Washington Manual,* and spend hours on end on the wards and in the clinic and in the lab and in their offices. They will choose their residencies, move their families, work indefatigably caring for the affluent and the indigent alike, move their families again, and finally begin their lives as physicians.

They know medicine will be much different in its logistics, economics, and politics when they finally reach this point. They believe that whatever changes occur will leave intact the relationship between doctor and patient. They hope that they will be able to fully experience the joy we have found in that relationship.

Many times in the last several years, I have heard physicians decry our current plight and wonder aloud why any sane individual would want to become a physician now. Many students have voiced their surprise when a physician acquaintance or family member has urged them not to pursue a medical career. Fortunately for all of us, they still want to be like us, and in this we should all find great comfort.

Daniel Varga, MD

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We Join Hands In Helping The Medical Students of Today
Be Our Physicians of Tomorrow
THROUGH AMA-ERF





144TH KMA ANNUAL





Top: Newly elected President Robert R. Goodin, MD, is pictured with, L to R, Secretary-Treasurer William P. VonderHaar, MD, President-Elect Danny M. Clark, MD, and Vice President William H. Mitchell, MD. Bottom L to R: KMA Past President Richard F. Hench, MD, AMA Executive Vice President James M. Todd, MD, and KMA Executive Vice President Robert G. Cox, participated in a reference committee; President Robert R. Goodin, MD, presented the Past President's plaque to Ardis D. Hoven, MD.







MEETING





Clockwise from top left: President-Elect Donny M. Clork, MD, wos escorted to the podium by Post Presidents Donold C. Borton, MD (L) ond Preston P. Nunnelley, MD; Board Chairman Donold R. Stephens, MD, administered the presidentiol ooth to Dr Goodin; President Ardis D. Hoven, MD, introduced AMA Executive Vice President James M. Todd, MD, to the House of Delegates. Joining Dr Goodin ot the President's Luncheon was his fomily, L to R, son Bobby, wife Corol, ond doughters Karo and Jodi; Awards Choirmon Nelson B. Rue, MD (L), presented the Loy Person Aword to Williom M. Lear, Jr, 79th District State Representative.







Top L to R: KMIC Board Chairman Richard F. Hench, MD, delivered a report to the House of Delegates; President Ardis D. Hoven, MD, presented the Educational Achievement Award to Richard W. Schwartz, MD, a Lexington surgeon. Left: President Robert R. Goodin and KMA Executive Vice President Robert G. Cox chatted following the President's Luncheon. Bottom: KMAA Past President Gloria Griffin presented AMA-ERF checks to UK Dean Emery A. Wilson, MD, and U of L Dean Donald R. Kmetz, MD (L), as Vice Speaker C. Kenneth Peters, MD, looked on.



Inauguration

Robert R. Goodin, MD, a Louisville cardiologist, was inaugurated 1994-95 President of KMA at the 144th Annual Meeting held in Louisville, September 19-22. A graduate of the University of Louisville School of Medicine, Dr Goodin served as a KMA alternate delegate to the AMA House of Delegates from 1986 until 1990, and has served as a KMA delegate to the AMA since 1991. He has chaired several KMA committees and currently serves on the CME Advisory Committee at AMA.

Board of Trustees — Elections

The KMA Board of Trustees held its reorganizational meeting for the 1994-95 Association year on September 22, 1994. Acting as temporary Chair, KMA Secretary-Treasurer William P. VonderHaar, MD, introduced the newly elected members of the Board and the new officers: Danny M. Clark, MD, Somerset, President-Elect; William H. Mitchell, MD, Richmond, Vice President; C. Kenneth Peters, MD, Jeffersontown, Speaker, House of Delegates; John W. McClellan, MD, Henderson, Vice Speaker, House of Delegates; Donald R. Neel, MD, Owensboro, Trustee, 2nd District; and Kenneth R. Hauswald, MD, Ashland, Trustee, 13th District.

The Board elected the Executive Committee members to serve with the President, President-Elect, Vice President, and Secretary-Treasurer for the 1994-95 KMA year. Don R. Stephens, MD, was reelected Chair, Board of Trustees, and Harry W. Carloss, MD, Paducah, was elected Vice Chair. Scott B. Scutchfield, MD, Danville, and Russell L. Travis, MD, Lexington, were named as Trustees-at-large.

It was noted that the KMA Executive Committee members also serve as the Board of Directors of KMA Physicians Services, Inc (KMA's holding company). The Board also

made changes to the Kentucky Foundation for Medical Care Board of Directors in accordance with KFMC's Bylaws, and appointed KMA committees for the following year.

The next meeting of the Board was scheduled for December 14-15, 1994.

Five physicians were elected by the House of Delegates to serve on the 1995 Nominating Committee. Members elected were:

James R. Bean, MD
Lexington, Chair
James D. Crase, MD
Somerset
Joe T. Davis, MD
Bowling Green
Jayne L. Hollander, MD
Louisville
Michelle M. Murray, MD
Alexandria

President's Luncheon

The President's Luncheon guests honored outgoing President Ardis D. Hoven, MD, and witnessed the



Right: In a light moment, Immediate Past President Ardis D. Hoven, MD, shared her now legendary advice with new KMA President Goodin, "You're on your own — I'm not your mother."









Top down, center: Upon being announced President-Elect, Danny M. Clark, MD, asked his wife, Joyce, to stand and be recognized for the part she has played in his achievements. Mrs Clark is President of the KMA Alliance. Bottom L to R: Then House Speaker and current President-Elect, Danny M. Clark, MD, presided at the House of Delegates; President Robert R. Goodin, MD, and Donald Clapp, Chairman of the Kentucky Health Policy Board, addressed the group.

Top: KMA Past President Carl Cooper, Jr, congratulated newly inaugurated President Goodin. Center: The KMA Alliance had exemplary representation with these three members. L to R are President Joyce Clark, Past President and Southern Medical Association Auxiliary President-Elect Jo Ann Daus, and Immediate Past President Gloria Griffin. Bottom: C. Milton Young, III (L), and A. O'tayo Lalude were seated with other Jefferson County Delegates. Dr Lalude currently serves KMA as Chair of the Technical Advisory Committee on Physician Services (Title XIX).







installation of Robert R. Goodin, MD, as the 144th President of KMA.

In his Inaugural Address, Dr Goodin focused on pride in the medical profession. Notable comments included, "The ultimate reason for us to be proud of this profession is the opportunity to serve patients who need our help. Society has truly granted us a unique privilege to practice medicine. . . . I know of no other profession that offers such endless intellectual stimulation and challenge throughout one's career. . . . I am very proud of the fact that since the inception of the Nobel prize, half of all Nobel prizes in medicine have been awarded to American physicians. And I might add that not one Nobel prize in medicine has been awarded to a physician in Canada." Dr Goodin's address is printed in its entirety in the October 1994 *Journal*.

DSA Award

Each year the Kentucky Medical Association presents the Association's highest award to a member who has served their community, their state, and their profession with honor.

The 1994 recipient of the Distinguished Service Award was unable to attend this year's presentation as he and his wife were out of the country. The recipient will be formally named and presented the award at the 1995 Annual Meeting in Lexington.

Lay Person Award

The KMA Award, which is awarded to a lay person who has made significant contributions to the medical community, was presented to William M. Lear, Jr, 79th District State Representative from Lexington. Mr Lear is generally considered by members of the General Assembly and Kentucky experts as the most effective legislator in the Kentucky General Assembly.

In his presentation of the award to Mr Lear, Awards Chair Nelson B. Rue, MD, included these comments:

"In the mid-1980s medical liability insurance companies were withdrawing from the market and Kentucky physicians were inundated with professional liability claims and awards. The Kentucky General Assembly appointed a special task force to study tort reform and to develop recommendations for reforming the liability segment of our legal system. The most crucial aspect of the outcome of the reform measures was House leadership's selection of a point man to sponsor and represent the leadership before the various committees as the bill worked its way through the General Assembly. There were few surprises when today's honoree was asked to accept this tremendous responsibility. As a result of his labors, the General Assembly adopted numerous reforms in the malpractice arena including joint and several liability, abolished or restricted punitive damages, legislation relating to frivolous lawsuits, certificate of merit, review of awards, including raising or lowering them if the court believes amounts are excessive or inadequate.

During this same period, our honoree was extremely concerned that Kentucky law did not require children to be placed in child restraints. He worked very hard to accomplish this goal. He was also a consistent sponsor and advocate of the mandatory seat belt law, and we saw the fruition of his efforts when the 1994 Kentucky General Assembly adopted the mandatory seat belt legislation. The recipient of the 1994 KMA Award has worked with medicine on many proposals relating to health care and was extensively involved in opposing negative aspects of House Bill 250, including the provider tax. During this period of time, he worked closely with the Fayette County Medical Society and others supporting medicine's





Top: Medical school classmates (UK College of Medicine, class of 1970) and fellow KMA officers, L to R, Vice President William H. Mitchell, MD, Immediate Past President Ardis D. Hoven, MD, and Past President Preston P. Nunnelley, MD. Left: Newly elected 2nd District Trustee Donald R. Neel, MD (L), is pictured with Delegate R. Wathen Medley, Jr, MD. Bottom: President-Elect Clark chats with (L to R) Board Chair Don Stephens, MD, newly elected Speaker C. Kenneth Peters, MD, and KMIC President and CEO Steven L. Salman.







Top: L to R, 15th District Trustee Paul R. Smith, MD, takes a break from House action with R. Parnell Rollings, MD, and Delegate Harold D. Haller, MD, both from Jefferson County. Center: Jefferson County Delegates Susan G. Bornstein, MD, and Lynn T. Simon, MD, discussed the House agenda. Bottom: 14th District Trustee E. D. Roberts, MD, and Delegate Mary Lyn T. Lu, MD, continued to discuss the issues during a break in House action.



proposals throughout his career as state representative. Unfortunately, for the citizens of Kentucky and medicine, he has announced his retirement from the General Assembly effective December 1994.

Our distinguished and honored 1994 recipient has received many awards for his work promoting quality health care. He is presently a board member of the Greater Bluegrass Association for Retarded Citizens; a board member of the Bellewood Children's Home; serves on the Child Development Centers of the Bluegrass; and was a member of the State Task Force on Runaway and Homeless Youth. These are just a few examples of the worthy service that he has given to his community and the Commonwealth.

The presentation of this award today is noteworthy. First of all, for the first time in this Association's 144-year history, we present this prestigious award to an elected official. Secondly, the gentleman whom we honor today epitomizes the high standards and integrity we seek and expect in our elected officials. He is truly a role model for those interested in a career of public service."

Educational Achievement Award

The recipient of the 1994 KMA Educational Achievement Award was Richard W. Schwartz, MD, a Lexington surgeon. He achieved distinction for his accomplishments in educating physicians and allied health personnel at the University of Kentucky College of Medicine.

Dr Schwartz serves as Associate Professor, Department of Clinical Science/CNU, College of Allied Health Professions, University of Kentucky. His teaching activities include service as Director, Undergraduate and Graduate Surgical Education in the Department of Surgery, and the Director of Joint Activities in

Medicine-Surgery Clerkship in the Departments of Surgery and Medicine at UK.

He has served as the Chair of the Research Committee and as a member of the Executive Board of the Association for Surgical Education, and currently serves as a member of the Executive Council of the Association for Academic Surgery, as well as a reviewer for the *Journal of Academic Medicine, Teaching and Learning in Medicine*, and the *American Journal of Surgery*.

He received the Clinical Golden Apple Teaching Award at the University of Kentucky in 1989, and has received an award for Excellence in Teaching in the Department of Surgery every year since 1990.

Dr Schwartz is a member of KMA and the Fayette County Medical Society.

Scientific Exhibit Award

Several excellent Scientific Exhibits were displayed at the 144th KMA Annual Meeting. The award winner was an outstanding presentation by the Kentucky Cancer Program.









Top: William C. DeVries, MD (R), Louisville, is pictured with State Auditor Ben Chandler of Frankfort. Center: Past President Nelson B. Rue, MD, and his wife, Sue, enjoyed the President's Luncheon. Bottom L to R: Delegate Jannice O. Aaron, MD, shared a lighter moment with President Hoven; Kenton County Delegate Marguerite S. Schabell, MD, and Past President William B. Monnig, MD, had a discussion with Fayette County Delegate Andrew R. Pulito, MD.

Alliance AMA-ERF

During the first meeting of the House of Delegates, Gloria Griffin, KMAA Past President, presented AMA-ERF checks to the two medical schools on behalf of the Alliance. Since 1950, the AMA-ERF has continually been supportive of quality medical education, with contributions now exceeding $2 million annually. The extraordinary fund raising efforts of the AMA Alliance and the generosity of contributing medical families and private enterprise continue to secure AMA-ERF as a viable support for medical education.

In Kentucky, AMA-ERF funds are given proportionally to the two medical schools as designated by the donors. Donald R. Kmetz, MD, Dean of the University of Louisville School of Medicine, accepted a check from Mrs Griffin for $23,845.66, and Emery A. Wilson, MD, Dean of the University of Kentucky College of Medicine, accepted a check for $15,307.38.



Delegates sometimes had all of the floor microphones in use simultaneously as they debated the issues before the House.

Fifty-Year Members

Those KMA member physicians who have been practicing medicine for 50 years or more were recognized during the President's Luncheon. Achieving that status this year are: Drs Charles E. Allen, Jr, Carl A. Anderson, John E. Bickel, Curtis E. Bippert, Charles J. Bisig, Charles L. Bland, William A. Blodgett, Charles O. Bruce, Jr, Henry S. Collier, Emmanual R. Coronel, Harry C. Denham, William C. Durham, Harold G. Eskind, James Robert Flautt, Jr, M. Randolph Gilliam, John F. Greene, Richard F. Grise, William P. Hall, William C. Hambley, Nathan Handelman, James C. Hart, Paul M. Hulett, Max P. Jones, Arthur H. Keeney, W. Vernon Lee, Robert J. Lehman, William P. Linss, Willard A. Litzenberger, Margaret B. Magruder, Richard E. Mardis, Roy A. Martin, Edward N. Maxwell, Lloyd D. Mayer, Robert J. McCabe, William E. McDaniel, Dexter Meyer, Jr, Herman R. Moore, David K. Mulliken, C. Edward Rankin, James M. Riley, Jr, Harold D. Rosenbaum, John H. Scott, Jr, Millard R. Shaw, Raymond C. Snowden, James B. Stith, Daniel A. Tobin, Jesse O. VanMeter, Jr, R. Dietz Wolfe, Howard V. Ziegel.

In Memoriam

During the first House of Delegates meeting, Secretary-Treasurer William P. VonderHaar, MD, requested that the audience stand for a moment of silence in memory of those physician members who had died in the last year. A list of the deceased appears on page 489 of this *Journal.*

KMA-MSS and RPS

At the 1994 joint KMA MSS/RPS Annual Meeting on September 20, medical students from UK and UL, as well as residents from all four residency programs in Kentucky, heard a very informative and thought-provoking panel discussion on "Workforce Planning — The Future of Medicine." Panelists included: Andrew Thomas, AMA-MSS Governing Council member and 4th-year medical student, Ohio State University College of Medicine; Judy Linger, MD, KMA-RPS President and AMA-MSS Governing Council member; and Robert R. Goodin, MD, KMA President and AMA Delegate.

KMA Trustee and family physician, Ronald Waldridge, MD, Shelbyville, gave a touching presentation on the "art" of medicine as it impacts on physicians' images and challenged the students and residents to strive in patient care to be "RDs" ("real" doctors) first.

KEMPAC

The 32nd KEMPAC Seminar Banquet was held during this year's Annual Meeting on Monday, September 19, at the Hyatt Regency Hotel, Louisville. A large audience of physicians, spouses, Kentucky State Representatives, Senators, and their staff heard a very inspiring address by James S. Todd, MD, Executive Vice President of the



General Scientific Sessions drew an overflow audience with their many excellent guest speakers.

American Medical Association. KEMPAC Chairman, James D. Crase, MD, Somerset, presided at the meeting.

House Action Summary

On Monday, September 19, 1994, James S. Todd, MD, addressed the KMA House of Delegates regarding the status of health system reform at the national level. AMA Executive VP Todd outlined the American Medical Association's two-part strategy in dealing with health system reform in Washington.

First, the AMA is advocating the Patient-Protection Act, which guarantees that physicians and their patients make important decisions about medical care, rather than the insurance company. Secondly, the AMA is supporting the Hatch Archer Antitrust Bill, which will let doctors compete and form networks on a playing field level with the insurance companies and other competitors. Dr Todd explained that regardless if Congress fails to pass health system reform legislation this year, both bills will be ready for the next session of Congress.

Dr Todd also commented on the willingness of the AMA to support the KMA in its efforts to tackle the implementation of HB 250 and other health care measures enacted by the 1994 Kentucky General Assembly. Dr Todd assured the House of Delegates that the AMA is working with KMA officers and general counsel to communicate with the Health Care Financing Administration (HCFA) regarding the waiver requested by the Cabinet for Human Resources for the Medicaid program.

The second meeting of the KMA House of Delegates on Wednesday, September 21, 1994, included adoption of several resolutions related to the Medicaid program and HB 250.

- Resolution U calls for the KMA to continue to support the Kentucky Physicians Care Program; contact the Kentucky Congressional Delegation and explain the potential ramifications reimbursement cuts will have on access to care for the poor and Medicaid recipients; explore legal ramifications of drastic reductions in Medicaid reimbursement, particularly as it relates to the Boren Amendment; alert HCFA and other federal agencies, along with patient advocacy organizations including representatives of senior groups; make it known that if corrective action is not achieved KMA can no longer urge its members to support a Medicaid program that is not in the best interest of patient access to care; and forward this information to every television, radio station, and newspaper in Kentucky.
- A Substitute Resolution on HB 250 was adopted which calls for KMA to work steadfastly, by all reasonable legislative and legal methods, up to and including petitioning the US Supreme Court, to overturn onerous portions of HB 250, especially regarding those portions related to patient record confidentiality, reproduction of patient records without reimbursement, and standardized insurance plans.
- Resolution W recommends that KMA demand a retraction of the story and a public apology to physicians named in the article "Medicaid Has First Million-Dollar Doctor" by the *Courier-Journal* on September 8, 1994, and correspond directly with the Gannett Corporation, parent company of the *Courier-Journal*, requesting an investigation of the inaccuracies in the Medicaid articles. KMA should also correspond with the Kentucky Press Association and other journalistic societies to seek ethical review of the Medicaid stories, writers, and editors.
- Resolution A calls for KMA to design and implement a plan to allow physicians to pass through the 2% provider tax; disseminate printed materials identifying elected officials who supported the taxing provisions of HB 250 and how patients can voice concerns; develop and disseminate a legislative strategy to rescind the tax in the 1996 Legislature; and develop a process to test the legality of passing through the provider tax to various

patient constituencies or the constituencies' payors.

Additional highlights of House action are listed below.

- Expressed sincere gratitude and thanks to Ardis D. Hoven, MD, for her exemplary leadership over the past year as President, especially her untiring efforts during the 1994 Kentucky General Assembly working on HB 250 and other health reform issues, and taking part in the health system reform seminars held in all 15 KMA Trustees Districts.
- Recommended KMA establish a repository for instances of economic credentialing and provide the information to the Hospital Medical Staff Section for review.
- Recommended KMA work with the Kentucky Restaurant Association in a voluntary effort to encourage the designation of all Kentucky restaurants as smoke free or create adequate nonsmoking areas and encourage county medical societies to work with local restaurant associations and local restaurants to promote voluntary creation of nonsmoking dining areas.
- Recommended KMA urge consideration of the inclusion of Sleep Medicine in AMA codes for Self-Designation by the appropriate committee of the American Medical Association.
- Commended the CME Committee for its leadership provided to intrastate accredited sponsors and for its 4-year recognition status by the Accreditation Council on Continuing Medical Education (ACCME), its longest recognition period to date.
- Recognized Wally O. Montgomery, MD, as Chair, Committee on State Legislative Activities, for his contribution of time, effort, and involvement during the 1994 General Assembly.
- Accepted the report of the Committee to Investigate Changing Trends in Medicine and recommended that this information be made known to members through KMA publications.
- Recommended that KMA support and encourage formal training for students and residents on substance abuse and impairment in Kentucky's medical schools and inform the medical schools and residency programs of the services of the Kentucky Physicians Health Foundation to assist in developing such training opportunities.
- Recommended that obstetricians be regarded as primary care physicians to their obstetrical patients during the perinatal period.
- Recommended that ophthalmologists be regarded as comprehensive (primary, secondary, and tertiary) eyecare providers and have KMA inform the Kentucky Insurance Commissioner, all third-party payors in the Commonwealth of Kentucky, and the Kentucky Health Policy Board.
- Recommended KMA recognize that laser procedures are surgical and inform the Kentucky Board of Medical Licensure and the Kentucky Health Policy Board that the use of lasers is a surgical procedure and that only those practitioners licensed to perform surgery should be authorized to utilize laser therapy.
- Recommended that a copy of the information from the Committee on Maternal and Child Health regarding guidelines for hospital discharge of the mother and newborn be sent to individuals and institutions involved with obstetrics and newborn care.
- Recommended that the KMA communicate directly with the leadership of the Burley Tobacco Growers' Cooperative Association regarding support for the Kentucky Organic Growers and urge physicians, clinics, hospitals, medical societies, and other medical entities to assist Kentucky Organic Growers by supporting Kentucky agriculture.
- Recommended that the annual voluntary assessment of the KMA membership to the Legal Trust Fund be set at $25.00 and strongly urge all KMA members to voluntarily contribute to the Legal Trust Fund.

Please refer to the House of Delegates section in this *Journal* for a complete text of the Committee Reports and Resolutions.

Attendance

This year's KMA meeting attracted an outstanding crowd of 2,497. Physicians numbered 1,267 and medical students 293, resulting in a very successful 144th KMA Annual Meeting at the Hyatt Regency Hotel/ Commonwealth Convention Center in downtown Louisville.

The 1995 Annual Meeting will be held in Lexington. The Board of Trustees has again selected the very accommodating and spacious Hyatt Regency Hotel/Lexington Center to house the meeting. Over 22 specialty groups and an estimated 2,600 registrants are expected to attend.

Please mark your calendars to attend the 1995 KMA Annual Meeting to be held September 17-21.

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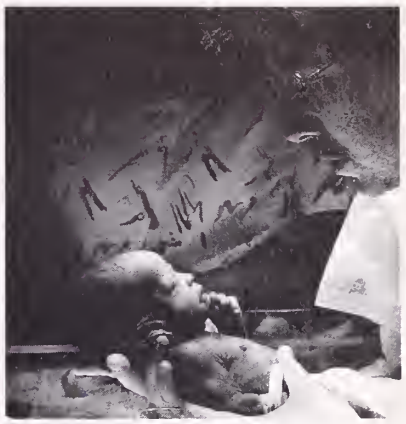
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Rural Health

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National Rural Health Association
May 17–20, 1995
Atlanta, Georgia

You respond to them. You support them. You fight for them.



The AMA responds, supports and fights for you.

Everyday, you help ease suffering, heal patients and save lives. It is an ennobling calling. **The AMA shares your values.** Your patients' health is our highest priority, too. As the world's preeminent medical organization, our 300,000 member physicians work together for the benefit of all Americans. We speak out on behalf of patients and physicians with a single, powerful voice. We advance the art and science of medicine. We promote ethical, educational and clinical standards for the profession. **We are partners in a lifelong crusade.** When you become an AMA member, you are expressing your commitment to patients, to the profession, and to resolving the great health care issues of our time. Join us now. Call your county or state medical society, or AMA at **800 AMA-3211.**

American Medical Association
Physicians dedicated to the health of America

Together, we are the profession.



State Representative and KMA Past President Bob DeWeese, MD, Louisville.



State Representative Jeffrey Buis, Liberty.



Senate candidate Julie Carman Rose.



L to R, KMA Past President Donald Barton, MD, his wife Joan, and Steve Clark, Louisville, candidate for State Representative.



KEMPAC Board member Barbara Haas and Senator Dick Roeding, Ft. Mitchell.



L to R, Drs Lolita and Sam Weakley with Congressional candidate Mike Ward, Louisville.



KMA Secretary-Treasurer and KEMPAC Board member William VonderHaar, MD, and Jefferson County Commissioner Steve Henry.



AMA Executive Vice President James S. Todd, MD.



L to R, Senator Walter Baker, Glasgow, KMA President Robert Goodin, MD, and Congressional candidate Susan Stokes, Louisville.

KEMPAC

A distinguished group of state leaders, KMA members, and their spouses attended the KEMPAC Seminar Banquet held during the KMA Annual Meeting. AMA Executive Vice President James S. Todd, MD, addressed the group, and KEMPAC Chair James D. Crase, MD, presided at the meeting. Several in attendance are recognized in this spread of photos.



L to R, Fayette County Executive VP Carolyn Kurz, Thomas Slabaugh, MD, Jim Bean, MD, and Senator Tim Philpot, all of Lexington.

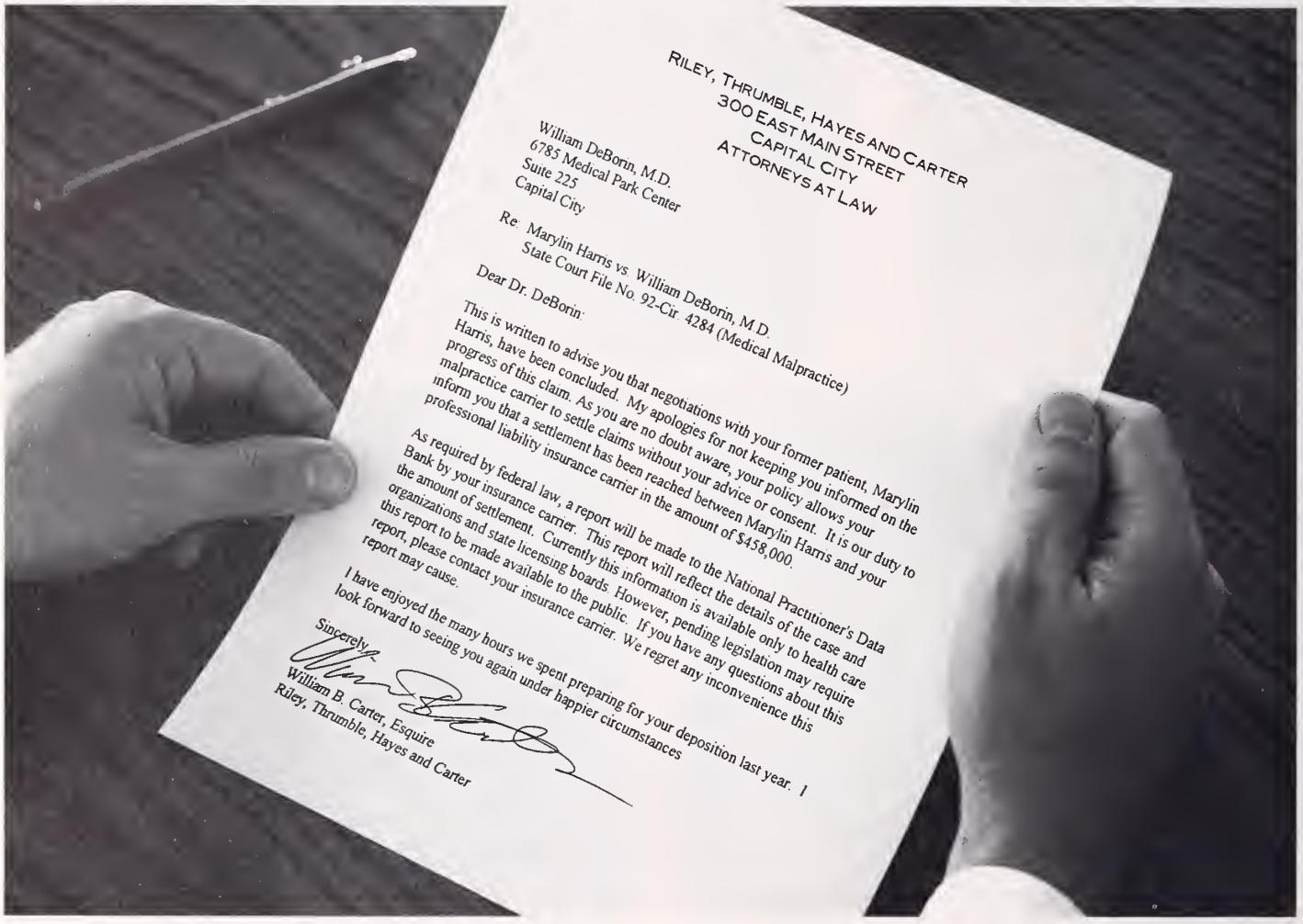


Senator David Williams (L), Burkesville, and Russell Travis, MD, Lexington.



L to R, KEMPAC Chair Jim Crase, MD, Somerset, Senator Tom Buford, Nicholasville, and Rebecca Harilson, Administrative Assistant, Senate Republican leadership.

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300 EAST MAIN STREET
CAPITAL CITY
ATTORNEYS AT LAW

William DeBorin, M.D.
6785 Medical Park Center
Suite 225
Capital City

Re: Marylin Harris vs. William DeBorin, M.D.
State Court File No. 92-Cir. 4284 (Medical Malpractice)

Dear Dr. DeBorin:

This is written to advise you that negotiations with your former patient, Marylin Harris, have been concluded. My apologies for not keeping you informed on the progress of this claim. As you are no doubt aware, your policy allows your malpractice carrier to settle claims without your advice or consent. It is our duty to inform you that a settlement has been reached between Marylin Harris and your professional liability insurance carrier in the amount of $458,000.

As required by federal law, a report will be made to the National Practitioner's Data Bank by your insurance carrier. This report will reflect the details of the case and the amount of settlement. Currently this information is available only to health care organizations and state licensing boards. However, pending legislation may require this report to be made available to the public. If you have any questions about this report, please contact your insurance carrier. We regret any inconvenience this report may cause.

I have enjoyed the many hours we spent preparing for your deposition last year. I look forward to seeing you again under happier circumstances

Sincerely,

William B. Carter, Esquire
Riley, Thrumble, Hayes and Carter

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ROLL CALL
1994 House of Delegates
KMA Annual Meeting

OFFICERS

		First Meeting	Second Meeting
Speaker	Danny M. Clark	.....	Present
Vice Speoker	C. Kenneth Peters	Present	Present
President	Ardis D. Hoven	Present	Present
President-Elect	Rabert R. Gaadin	Present	Present
Vice-President	Williom H. Mitchell	Present	Present
Secretary-Treasurer	William P. VanderHaar	Present	Present
Delegate ta the AMA	Danald C. Bartan	Present	Present
Delegate ta the AMA	Robert R. Gaadin	Present	Present
Delegate ta the AMA	Ardis D. Haven	Present	Present
Delegate ta the AMA	Wally O. Mantgamery	Present	Present
Alternate Delegote to the AMA	J. Gregary Caaper	.....	.....
Alternate Delegate to the AMA	Bab M. DeWeese	Present	Present
Alternote Delegote ta the AMA	Prestan P. Nunnelley	Present	Present
Alternate Delegote to the AMA	Danald J. Swikert	Present	Present

TRUSTEES

District			
First	Harry W. Coroloss	Present	Present
Secand	John W. McClellon, Jr	Present	Present
Third	William H. Klompus	Present	Present
Faurth	Salem M. Gearge	.....	Present
Fifth	Joseph E. Kutz	Present	Present
Sixth	Timothy K. Hulsey	Present	Present
Seventh	Ranald L. Waldridge	Present	Present
Eighth	Mark F. Pelstring	Present	Present
Ninth	Danald R. Stephens	Present	Present
Tenth	Russell L. Travis	Present	Present
Eleventh	G. Irene Minar	Present	Present
Twelfth	Scott B. Scutchfield	Present	Present
Thirteenth	Chorles T. Watsan	Present	Present
Faurteenth	Elster D. Raberts	Present	Present
Fifteenth	Poul R. Smith	Present	Present

ALTERNATE TRUSTEES

District			
First	Dan M. Miller	Present	.....
Secand	Christapher R. McCay	.....	.....
Third	Charles R. Dadds	Present	.....
Faurth	Jeffrey B. Richardsan	Present	Present
Fifth	Larry J. Wilsan	Present	Present
Sixth	J. Michael Pulliam	Present	Present
Seventh			
Eighth	John D. Amman	.....	.....
Ninth	Rabert L. McKenney	Present	Present
Tenth	Gary R. Wallace	.....	.....
Eleventh	Richord A. Stane	Present	Present
Twelfth	Danald E. Brawn	Present	.....
Thirteenth	Bruce M. Stapletan	.....	.....
Faurteenth			
Fifteenth	Ragelia A. Acosta	.....	Present

PAST PRESIDENTS

Post President	William B. Mannig	Present	Present
Past President	S. Randalph Scheen	.....	Present
Past President	Preston P. Nunnelley	Present	Present
Past President	Nelson B. Rue	Present	Present
Past President	Bab M. DeWeese	Present	Present

DELEGATES
FIRST DISTRICT

		First Meeting	Second Meeting
BALLARD	Morcho C. Robinsan	.....	.....
CALLOWAY	R. Gory Morquordt	Present	Present
	Dan Miller	Present	.....
CARLISLE			
FULTON	Edward B. McWhirt	.....	.....
GRAVES	Chorles E. Bea	Present	Present
	Patricia S. Elliatt	.....	.....
HICKMAN	Bruce C. Smith	.....	.....
LIVINGSTON	Stephen Burkhart	.....	.....
MARSHALL			
MCCRACKEN	W. Winstan Barnard	Present	Present
	Francis J. Black, III	.....	Present
	James R.Gauld	.....	.....
	Jahn E. Grubbs	.....	.....
	Rabert M. Haugh	Present	Present
	Peter E. Lacken	Present	Present
	Jahn D. Naanan	Present	Present
	Jahn M. Pierce	Present	.....
	Allen L. Tinsley	.....	.....
	Ranald L. Wilsan	.....	.....

SECOND DISTRICT

DAVIESS	Jack C. Blackstane, Jr	Present	.....
	Gerald G. Edds	.....	.....
	William C. Harrisan	Present	Present
	Christapher J. Havelda	Present	Present
	Jahn D. Laucks	Present	Present
	R. Wathen Medley, Jr	.....	Present
	Rabert H. Schell	Present	Present
	William L. Tyler, III	Present	Present
HANCOCK			
HENDERSON	John S. Cave	Present	Present
	Morcio L. Cove	Present	Present
	Joseph H. Horpole, Jr	Present	.....
	Frank K. Sewell, Jr	.....	.....
MCLEAN			
OHIO			
UNION	Wallas N. Bell	Present	Present
WEBSTER			

THIRD DISTRICT

CALDWELL			
CHRISTIAN			
CRITTENDEN	Haward Gregory Maddux	.....	.....
HOPKINS	Walloce R. Alexander	Present	Present
	James M. Bawles	Present	Present
	Uday V. Dove	Present	Present
	Mohan K. Raa	Present	Present
LYON			
MUHLENBERG	William L. Miller	.....	.....
TODD			
TRIGG			

FOURTH DISTRICT

BRECKINRIDGE			
BULLITT			
GRAYSON			
GREEN	Harry B. Huntsman	.....	.....
HARDIN-LARUE	Vivian H. Bland	.....	.....
	David Daa	.....	.....
	Amarjit M. Desai	.....	.....
	Lucion Yonn Moreman, II	Present	Present
	Jeffrey B. Richardsan	Present	Present

HART	Clem E. Nichols	.....	.....
MARION	Richard V. Steeves	Present	Present
MEADE			
NELSON			
TAYLOR	Eugene H. Shively	Present	Present
WASHINGTON	Charles D. Haward	.....	.....
	Suk K. Kah	.....	Present
	Brian F. Wells	Present	.....

FIFTH DISTRICT

JEFFERSON	Jannice O. Aaran	Present	Present
	David T. Allen	Present	Present
	Kenneth C. Andersan	.....	Present
	Jaseph C. Banis, Jr	.....	Present
	Arnald M. Belker	.....	Present
	Susan M. Berberich	.....	Present
	James L. Bersat, Jr	.....	.....
	S. J. Bertolane, Jr	.....	Present
	Charles J. Bisig, Jr	Present	Present
	David H. Bizat	.....	Present
	Susan G. Bornstein	.....	Present
	C. Matthew Brown	.....	.....
	Gregary L. Brown	.....	.....
	William C. Buschemeyer, Jr	.....	.....
	David E. Bybee	Present	Present
	Peter C. Campbell	.....	Present
	Stuart P. Cahen	.....	.....
	Peter M. Conway	.....	Present
	Warren M. Cax, IV	.....	Present
	Frederick Cressman, Jr	.....	.....
	John H. Dayle	Present	Present
	Rudy J. Ellis, Jr	.....	Present
	Samuel G. Eubanks, Jr	Present	Present
	Rabin M. Floyd	.....	Present
	Gary L. Fuchs	.....	Present
	Hoyt Gardner	.....	Present
	Kotherine P. Garrisan	Present	Present
	Dorius Ghazi	.....	Present
	Linda Gleis	.....	Present
	Leanard A. Gaddy	.....	.....
	Harald D. Haller	Present	Present
	Kathleen C. Horter	.....	.....
	B. Thamos Horter, Jr	Present	Present
	Joyne L. Hollonder	.....	Present
	Wolter I. Hume, Jr	Present	Present
	Borbara Sue Isaacs	.....	Present
	Jahn Jurige, Jr	.....	.....
	Sheri A. Kalbfleisch	.....	Present
	Jahn M. Kariba	.....	Present
	Virginia T. Keeney	Present	.....
	Danald R. Kmetz	Present	Present
	A. O'tayo Lalude	.....	Present
	Michael T. Macforlane	.....	Present
	Russell T. Moy	Present	Present
	Martha T. McCoy	.....	Present
	Frank B. Miller	Present	Present
	Cathleen J. Morris	.....	.....
	Richord R. Marris	.....	Present
	Rabert L. Nold	.....	.....
	Chorles R. Oberst	.....	Present
	Habert L. Pence	.....	Present
	Steve J. Raible	.....	.....
	Jomes E. Redman	Present	Present
	K. Thomas Reichard	Present	.....
	William M. Renda	.....	.....
	Sheryl M. Schneider	.....	Present
	Gearge R. Schradt	.....	Present
	Gearge R. Schrodt, Jr.	Present	Present
	Edword L. Scafield	Present	Present
	Lynn T. Siman	.....	Present
	Judah L. Skalnick	.....	Present
	Wm. C. Templetan, III	.....	Present
	Regula J. Tabias	.....	Present
	Daniel W. Varga	.....	Present
	Gerald D. Verdi	.....	Present
	Henry J. Walter	Present	Present
	Norton G. Waterman	.....	Present
	Dovid R. Watkins	.....	.....
	Samuel D. Weakley	Present	Present
	Barbara Weakley-Janes	Present	Present
	A. Franklin White, Jr	.....	Present
	Jahn J. Whitt	.....	Present
	Russell A. Williams	.....	Present
	James Anthany Wright	.....	Present
	C. Miltan Yaung, III	Present	Present

SIXTH DISTRICT

ADAIR	Richard Lenaghan	.....	Present
ALLEN	Jahn M. Hall	.....	.....
BARREN	Ray A. Gibsan	.....	.....
	Marris David Mass	.....	.....
BUTLER	Richard T. Wan	.....	.....
CUMBERLAND	Joseph D. Skipworth	.....	.....
EDMONSON	Omkar N. Bhatt	.....	.....
LOGAN	Patrick K. Hayden	Present	Present
METCALFE			
MONROE	James E. Corter	.....	.....
SIMPSON	J. Michoel Pulliam	Present	Present
WARREN	James F. Beattie, Jr	Present	Present
	John T. Burch	Present	Present
	Jae T. Davis	.....	.....
	Rabert J. Emslie	Present	Present

SEVENTH DISTRICT

ANDERSON	Jomes D. Gilbert	.....	.....
CARROLL	Frank F. Polmer	Present	Present
FRANKLIN	Willis P. McKee, Jr	.....	.....
	Jahn M. Pattersan	.....	Present
	William F. Threlkeld	Present	Present
GALLATIN	Benjamin Kutnicki	Present	Present
GRANT	Daryl B. Shipp	.....	.....
HENRY	David W. Wallace	.....	.....
OLDHAM	Harald F. Funke	Present	Present
OWEN			
SHELBY	William H. Hanking	Present	.....
SPENCER	Thamas C. Crain	.....	.....
TRIMBLE	Raderick H. MacGregar	.....	.....

EIGHTH DISTRICT

BOONE	Michael L. Rabinsan	.....	Present
	James R. Schrand	.....	Present
	Chris Wang	Present	.....
CAMPBELL	James Evans, III	.....	Present
	Steven L. Willett	Present	Present
	Steven M. Waadruff	Present	Present
KENTON	Gardan W. Air	Present	Present
	Elbert D. Baldridge, Jr	.....	.....
	Philip S. Becker	.....	Present
	Thamas E. Bunnell	Present	Present
	Mark A. Cepela	.....	Present
	Christapher A. Heeb	.....	Present
	Rass McHenry	.....	Present
	Theadare H. Miller	Present	Present
	Richard E. Park	Present	Present
	Jahn F. Socco	.....	Present
	Marguerite S. Schabell	Present	Present
	B. Robert Schwartz	Present	Present

NINTH DISTRICT

BATH			
BOURBON	James L. Ferrell		
BRACKEN			
FLEMING	Glenn R. Wamack	.....	.....
HARRISON	Danald R. Stephens	Present	Present
MASON	Leray Shause	Present	.....
NICHOLAS			
PENDLETON	Rabert L. McKenney	Present	Present
ROBERTSON			
SCOTT	Curtis L. High	Present	Present

TENTH DISTRICT

FAYETTE	James W. Baker	Present	Present
	James R. Bean	Present	Present
	Jahn V. Barders	.....	Present
	Jahn W. Callins	Present	Present
	W. Lisle Daltan	Present	Present
	Elvis S. Danaldsan, Jr	Present	Present
	James E. Dunningtan, Jr	Present	Present
	Jahn M. Fax	.....	Present
	W. Jeffrey Faxx	.....	.....
	Bill H. Harris	.....	Present
	Richard F. Hench	.....	Present
	Raleigh O. Janes	.....	.....
	Mogdalene B. Karon	Present	Present
	Dennis B. Kelly	Present	Present
	Daniel E. Kenady, Sr	Present	Present
	William D. Medina	Present	Present
	Jahn M. Maore	Present	Present
	William N. Offutt, IV	Present	Present
	Charles L. Popp	.....	Present
	Barbara A. Phillips	Present	Present
	Jahn W. Paundstone	Present	Present
	Andrew R. Pulita	Present	Present
	Nat H. Sandler	.....	Present
	Glenn R. Shearer	Present	Present
	Thamas K. Slabaugh	Present	Present
	Jahn D. Stewart	Present	Present
	Jahn Rabert White	Present	Present
	Emery A. Wilsan	Present	Present
	William O. Witt	Present	Present
JESSAMINE			
WOODFORD	C. Dale Gaadin	.....	Present

ELEVENTH DISTRICT

CLARK	Daniel Alan Ewen	.....	.....
ESTILL	Jahn A. Pattersan	Present	.....
JACKSON			
LEE	James B. Noble	.....	.....
MADISON	L. Frank McBrayer	.....	.....
	William H. Mitchell	Present	Present
	Richard A. Stane	Present	Present
	Thamas J. Vaughon	Present	Present
MENIFEE			
MONTGOMERY			
OWSLEY			
POWELL			
WOLFE	Paul F. Maddax, Jr	.....	.....

TWELFTH DISTRICT

BOYLE	David C. Liebschutz	Present	Present
	Arthur K. Rivard	Present	Present
CASEY	Lewis E. Wesley	Present	Present
CLINTON	Tammy T. Brawn	.....	Present
GARRARD	Paul J. Sides	.....	Present
LINCOLN	C. Glen Click	.....	.....
MCCREARY			
MERCER	George W. Noe	Present	Present
PULASKI	Danald E. Brawn	Present	.....
	James D. Crase	Present	Present
	Joseph G. Weigel	Present	Present
ROCKCASTLE	William D. Dooley	.....	Present
RUSSELL	H. Michael Oghia	Present	Present
WAYNE	James K. Phillips, Jr	Present	Present

THIRTEENTH DISTRICT

BOYD	Paul W. Craig, II	Present	Present
	Kenneth R. Hauswald	Present	Present
	Haward B. McWharter	Present	Present
	Maurice J. Oakley	.....	Present
	Susan H. Prasher	Present	Present
CARTER	Paul R. Lewis	.....	Present
ELLIOTT			
GREENUP	Manuel S. Garcia	.....	Present
	Jahn O. Janes	Present	.....
LAWRENCE	George P. Carter	.....	Present
	William C. Tharndyke	.....	.....
LEWIS			
MORGAN	George R. Bellamy	.....	.....
ROWAN			

FOURTEENTH DISTRICT

BREATHITT			
FLOYD	Nichalas R. Jurich	Present	Present
	Chandra M. Varia	.....	.....
JOHNSON	Franklen K. Belhasen	.....	.....
KNOTT	W. Grady Stumba	.....	.....
LETCHER	Van S. Breeding	.....	.....
MAGOFFIN			
MARTIN	Lan E. Lafferty	.....	.....
PERRY	Gilroy Lone Doley	Present	Present
	Mitchell Wicker, Jr	.....	.....
PIKE	Mory Lyn T. Lu	.....	Present
	Lelo C. Moynord	.....	Present
	Chorles G. Nichols	.....	Present

FIFTEENTH DISTRICT

BELL	Emanual H. Rader	.....	Present
CLAY	William E. Becknell	.....	.....
HARLAN	F. Andrew Morfesis	.....	Present
	Mila H. Schosser	Present	Present
KNOX	Harald Bushey	.....	Present
LAUREL	Satyobroto Chotterjee	.....	Present
LESLIE	Roy Vorghese	.....	.....
WHITLEY			

KMA Resident Physicians Section—Donno Marlawe Skinker	Present	Present
U af K Student Delegate—LeAnn Simmons	Present	.....
U af L Student Delegate—Andrea Foulconer	.....	Present
KMA-HMSS—William D. Pratt	Present	.....

The infarmatian in the Roll Coll wos token from the ottendonce record cards signed by the delegates priar ta the meetings af the House, September 19 ond September 21.

1995 KMA
Practice Management Seminars

JANUARY

Update 1995: Medicare/CPT/ICD-9
January 10 - Executive Inn Owensboro
January 11 - JCMS Office, Louisville
January 12 - French Quarter Suites, Lexington

Gearing Up for Retirement
KMA-JCMS-KMIC sponsored
January 25 - Louisville

MARCH

Better Collections - half day
Reception Techniques - half day
March 15 - JCMS Office, Louisville

How to Get Started in Medical Practice
March 16-17 - JCMS Office, Louisville

APRIL

Advance Coding
April 19 - JCMS Office, Louisville

For further information, contact the KMA Office at (502) 426-6200.

KMA's 144th Annual Meeting



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Reference Committees

Special thanks to the Chairs and members of the Reference Committees for working so diligently to study committee reports, resolutions, and make recommendations to the full House of Delegates.



(L to R) Reference Committee 1: W. Ford Threlkeld, MD, Frankfart; Peter E. Locken, MD, Paducah; Jahn W. Collins, MD, Lexington, Chair; Mahan K. Rao, MD, Madisanville; Susan M. Berberich, MD, Louisville; James M. Bawles, MD, Madisanville.



Reference Cammittee 2: LeAnn Simmons, MSS, Lexingtan; Steven L. Willett, MD, Ft. Thamas; H. Michael Oghia, MD, Russell Springs; James F. Beattie, Jr, MD, Bowling Green; Daniel W. Varga, MD, Louisville; Thomas K. Slabaugh, MD, Lexington, Chair.



Reference Cammittee 3: Marcia L. Cave, MD, Henderson; B. Thomas Harter, Jr, MD, Louisville; James R. Bean, MD, Lexington, Chair; Jack C. Blackstone, Jr, MD, Owensboro; Thomas E. Bunnell, MD, Erlanger; Mark A. Cepela, MD, Edgewood.



Reference Cammittee 4: George R. Schrodt, Jr, MD, Louisville, Chair; Jaseph G. Weigel, MD, Samerset; William D. Medina, MD, Lexingtan; Gardan W. Air, MD, Crestview Hills; Andrea Faulcaner, MSS, Lauisville; Danna M. Skinker, MD, RPS, Lexingtan.



Reference Cammittee 5: Magdalene B. Karan, MD, Lexingtan; Michael Pulliam, MD, Franklin; Lucian Y. Moreman, MD, Elizabethtawn; Vaughn W. Payne, MD, Louisville, Chair; Jahn M. Patterson, MD, Frankfort; Susan H. Prasher, MD, Ashland.

The James W. Ellis, MD Memorial Meeting of the Kentucky Medical Association

Digest of Proceedings of the Regular Session of the

House of Delegates

Danny M. Clark, MD, Somerset
Speaker of the House
C. Kenneth Peters, MD, Jeffersontown
Vice Speaker of the House
Presiding

First Meeting
September 19, 1994

C. Kenneth Peters, MD, Vice Speaker of the KMA House of Delegates, called the first Meeting of the 144th Session of House of Delegates to order at 9:00 AM on Monday, September 19, 1994, at the Hyatt Regency Hotel, Louisville, Kentucky. He introduced KMA's Legal Counsel, Charles J. Cronan, IV, Louisville, and noted that the Speaker, Danny M. Clark, MD, Somerset, had been required to appear in court in Pulaski County that morning and would be unable to attend the First Meeting.

Following the invocation given by Sam D. Weakley, MD, Louisville, the Chair of the Credentials Committee, Kenneth R. Hauswald, MD, Ashland, reported that a quorum was present. A motion was made, seconded, and carried to approve the Minutes of the 1993 Session of the House of Delegates as published in the December 1993 *Journal of the Kentucky Medical Association.*

William P. VonderHaar, MD, Louisville, Secretary-Treasurer, announced that the Scientific Session would begin at 8:50 AM on Tuesday, September 20, and the President's Luncheon would be held on Wednesday, September 21, at which time the new President would be installed. Dr VonderHaar reminded the Delegates that Reference Committees would convene at 1:00 PM on Monday. He then asked the House members to stand for a moment of silence in memory of KMA members who had died since the 1993 Annual Meeting.

Vice Speaker Peters announced that the Rules Committee had prepared a booklet outlining the rules the House should follow in its deliberations. Ardis D. Hoven, MD, President, presented the Educational Achievement Award to Richard W. Schwartz, MD, Lexington. Gloria Griffin, Louisville, immediate past president of the KMA Alliance, presented AMA-ERF checks comprised of funds the Alliance had raised to benefit Kentucky's medical schools. Emery A. Wilson, MD, Dean, accepted a check in the amount of $15,307.38 on behalf of the University of Kentucky College of Medicine; and Donald R. Kmetz, MD, Dean, accepted a check for $23,845.66 on behalf of the University of Louisville School of Medicine.

Dr Peters noted that two special Resolutions had been introduced. The Resolutions were read, and a motion was made, seconded, and carried to adopt both as written.

Editorial Note: A tape recording was made of the two meetings of the House of Delegates, and any member who wishes to examine the transcript of these Proceedings may visit the Headquarters Office and listen to the recordings.

RESOLUTION

Memorial to Ray A. Cave, MD
KMA Board of Trustees

WHEREAS, Ray A. Cave, MD, who in life exemplified the highest ideas of medicine, unexpectedly succumbed on September 15, 1994, at the age of 60; and

WHEREAS, Doctor Cave served his patients and citizens of Leitchfield and Grayson County for over 30 years; and

WHEREAS, the Governor of Kentucky, the Kentucky Medical Association, the Kentucky Academy of Family Practice, and numerous other professional, public, and civic organizations recognized this kindly and remarkable gentleman and country doctor for his unselfish service to the poor; and

WHEREAS, Doctor Cave was scheduled to be honored on September 23, 1994 by the Health Care Access Foundation for treating more indigent patients free of charge than any other physician in Kentucky, while participating in the Kentucky Physicians Care Program; and

WHEREAS, Ray A. Cave, MD, through his actions and commitment to patient care through tremendous personal sacrifice, brought great credit to his profession and to this Association; and

WHEREAS, Doctor Ray Cave was a member in good standing of the Kentucky Medical Association representing his county as delegate along with service in various other offices in his county medical society and hospital medical staff; now, therefore, be it

RESOLVED, that the KMA House of Delegates hereby expresses its deepest sympathy to the family of Ray A. Cave, MD, and to his many friends and patients; and be it further

RESOLVED, that the opening session of the 1994 KMA House of Delegates adjourn in honor of Ray Cave, MD; and be it further

RESOLVED, that a framed copy of this resolution be presented to the Cave family with the respect and esteem of this Association; and be it further

RESOLVED, that this Resolution become a permanent part of the records and actions of this Association and the 1994 House of Delegates.

RESOLUTION

Tribute to Patricia K. Nicol, MD
J. Gregory Cooper, MD, Chair
Committee on Maternal and Child Health

WHEREAS, Patricia K. Nicol, MD, MPH, announced her retirement from State Government effective June 1, 1994, and

WHEREAS, Patricia Nicol has provided 40 years of service to public health in Kentucky, and

WHEREAS, Doctor Nicol has served with distinction in numerous capacities within the State Health Department and the Cabinet for Human Resources, and

WHEREAS, she has served since 1974, a period of 20 years, as Director of the Division of Maternal and Child Health, and

WHEREAS, Patricia Nicol has served the Franklin County Medical Society as President and has been a member of the KMA Committee on Maternal and Child Health where she has been of inestimable value to that Committee and its work, now therefore be it

RESOLVED, that the 1994 KMA House of Delegates recognize Patricia K. Nicol, MD, for her years of service to the medical profession, and the Commonwealth, and her unselfish devotion to the health of the mothers and children of Kentucky, and be it further

RESOLVED, that this Resolution be presented to Patricia K. Nicol, MD, with best wishes for a happy, well deserved retirement and with honor and esteem of this Association.

Dr Peters introduced the officers who presented their Reports. Each of the Reports was assigned to a Reference Committee as noted:

Report Number		Reference Committee
1	Report of the President Ardis D. Hoven, MD, Lexington	1
2	Report of the President, KMA Alliance Gloria Griffin, Louisville	1
3	Report of the President-Elect Robert R. Goodin, MD, Louisville	1
4	Report of the Speakers, House of Delegates Danny M. Clark, MD, Somerset C. Kenneth Peters, MD, Jeffersontown	1
5	Report of the Chair, Board of Trustees	1
	Report of the Ad Hoc Committee on DNR Donald R. Stephens, MD, Cynthiana	3
6	Report of the Secretary-Treasurer William P. VonderHaar, MD, Louisville	1
7	Report of the Editor A. Evan Overstreet, MD, Louisville	1
8	Report of the Delegates to AMA Donald C. Barton, MD, Corbin	1
9	Report of the Executive Vice President Robert G. Cox, Louisville	1
10	Report of the Kentucky Physicians Care Operating Committee Russell L. Travis, MD, Lexington	1
11	Report of KMA Physicians Services, Inc. Donald R. Stephens, MD, Cynthiana	1
12	Report of the Kentucky Medical Insurance Company Richard F. Hench, MD, Lexington	1
13	Membership Committee Harold D. Haller, Sr, MD, Lexington	1
14	Ephraim McDowell Cambus-Kenneth Foundation Ardis D. Hoven, MD, Lexington	1
15	Scientific Program Committee Sonia R. Teller, MD, Louisville	2
16	Scientific Exhibits Committee Richard A. Kielar, MD, Lexington	2
17	Continuing Medical Education Committee W. David Hager, MD, Lexington	2
18	Council for Continuing Medical Education James L. Borders, MD, Lexington	2
19	Cancer Committee Clinton C. Cook, III, MD, Louisville	2
20	Physician Manpower Committee Robert R. Goodin, MD, Louisville	2
21	Hospital Medical Staff Section John D. O'Brien, MD, Louisville	2
22	Rural Kentucky Medical Scholarship Fund Don R. Stephens, MD, Cynthiana	2
23	Maternal Mortality Study Committee John W. Greene, Jr, MD, Lexington	3
24	Committee on National Legislative Activities Donald C. Barton, MD, Corbin	3
25	Committee on State Legislative Activities Wally O. Montgomery, MD, Paducah	3
26	Committee on Professional Liability Insurance Wally O. Montgomery, MD, Paducah	3
27	Committee on Impaired Physicians Burns M. Brady, MD, Louisville	3
28	Committee on Care for the Elderly S. Philip Greiver, MD, Louisville	3
29	Public Education Committee Preston P. Nunnelley, MD, Lexington	3
30	Committee on Medical Insurance and Prepayment Plans Donald R. Neel, MD, Owensboro	4
31	Committee on Claims and Utilization Review K. Thomas Reichard, MD, Louisville	4
32	PRO Advisory Committee William H. Mitchell, MD, Richmond	4
33	Committee to Investigate Changing Trends in Medicine Margorie R. Fitzgerald, MD, Louisville	4
34	Young Physicians Steering Committee W. Ford Threlkeld, MD, Frankfort	4
35	Resident Physician Section Baretta R. Casey, MD, Pikeville	4
36	Medical Student Section Matt Shotwell, Lexington	4
37	Physician Organization Study Committee Robert R. Goodin, MD, Louisville	4
38	Committee on Maternal and Child Health J. Gregory Cooper, MD, Cynthiana	5
39	Technical Advisory Committee on Physician Services (Medicaid) A. O'tayo Lalude, MD, Louisville	5
40	Committee on Community and Rural Health Edmond A. Hooker, MD, Louisville, Chair	5
41	Committee on School Health, Physical Education, and Medical Aspects of Sports R. Quin Bailey, MD, Danville	5
42	Judicial Council William P. VonderHaar, MD, Louisville	5
43	Physician-Attorney Liaison Committee Lynn L. Ogden, II, MD, Louisville	5

New Business

New Business of the House was assigned to the Reference Committee indicated:

Resolution	Submitted by	Subject	Reference Committee
A	Northern Kentucky Medical Society	Provider Tax	3
B	Northern Kentucky Medical Society	Economic Credentialing	2
C	Resident Physician Section	Impairment Prevention and Education in the Training Years	4
D	Board of Trustees	KMA Legal Trust Fund	1
E	Estill County Medical Society	Kentucky Organic Growers	5
F	Bowling Green-Warren County Medical Society	House Bill 250	3
G	Bowling Green-Warren County Medical Society	Copying Patient Records	3

H	Jefferson County Medical Society	Provider Tax Awareness	3
I	Jefferson County Medical Society	Provider Tax Protest	1
J	Jefferson County Medical Society	Provider Tax Credits	1
K	Jefferson County Medical Society	Smoke-Free Dining	2
L	Jefferson County Medical Society	Regulatory Agencies	5
M	Fayette County Medical Society	Practice Environment in Kentucky	5
N	Fayette County Medical Society	Primary Care During Perinatal Period	4
O	Bowling Green-Warren County Medical Society	CME for Retired Physicians	2
P	Fayette County Medical Society	Expanded Indigent Care by Kentucky Physicians	1
Q	Fayette County Medical Society	Inclusion of Sleep Medicine in AMA Codes for Self-Designation	1
R	Fayette County Medical Society	Ophthalmologists as Primary Eyecare Providers	4
S	Fayette County Medical Society	Use of Laser Therapy	4
T	Fayette County Medical Society	Discount Option Program (DOP)	5
U	Board of Trustees	Medicaid	1
V	Board of Trustees	Discount Option Program	5
W	Board of Trustees	Character Assassination	2

Vice Speaker Peters announced the meeting locations for the Nominating Committee and for Trustee Districts electing Trustees and Alternate Trustees. He reminded the Delegates that the Nominating Committee would report at the close of the first Scientific Session on Tuesday morning.

The names of the Nominating Committee members were announced: James E. Redmon, MD, Louisville, Chair; Donald E. Brown, MD, Somerset; W. Lisle Dalton, MD, Lexington; Stephanie R. Hatfield, MD, Paducah; and Susan H. Prasher, MD, Ashland.

President Hoven introduced James S. Todd, MD, Executive Vice President of the American Medical Association, who delivered an address titled, "Tuning to the Real Message of Reform."

Vice Speaker Peters introduced the Chair of the newly appointed Kentucky Health Policy Board, Donald S. Clapp. Mr. Clapp summarized the duties and activities of the Board, which had been created as a result of HB 250 passed by the Kentucky General Assembly.

The Vice Speaker adjourned the First Meeting at 11:00 AM.

Second Meeting September 21, 1994

Danny M. Clark, MD, Speaker, House of Delegates, called the Second Meeting of the 1994 Session of the KMA House of Delegates to order at 7:00 PM on Wednesday, September 21, 1994.

Barbara Phillips, MD, Lexington, gave the Invocation, and Kenneth R. Hauswald, MD, Ashland, Chair of the Credentials Committee, reported that a quorum was present.

Secretary-Treasurer VonderHaar recognized guests from neighboring state medical associations who had attended the Annual Meeting. Included were Claire V. Wolfe, MD, President, Ohio State Medical Association; Dennis M. Burton, MD, President, West Virginia State Medical Association; Alan M. Roman, MD, President, Illinois State Medical Society; and Jerome Melchior, MD, Chairman of the Board, Indiana State Medical Association.

Don R. Stephens, MD, Chair, Board of Trustees, made a motion on behalf of the Board that William T. Watkins, MD, Somerset, be reelected to a four-year term on the Judicial Council. The motion was seconded from the floor and carried.

Richard F. Hench, MD, Lexington, Chair of the Kentucky Medical Insurance Company Board of Directors, presented an update on Kentucky Medical's status and activities.

The Speaker then called for the Reference Committee Chairs to present their Reports.

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 1

John W. Collins, MD, Lexington, Chair

1. Report of the President
2. Report of the President, Alliance
3. Report of the President-Elect
4. Report of the Speakers, House of Delegates
5. Report of the Chair, Board of Trustees, *except* for the following:
   Report of the Ad Hoc Committee to Implement Resolution M (1991) (Referred to Reference Committee No. 3)
6. Report of the Secretary-Treasurer
7. Report of the Editor
8. Report of the Delegates to AMA
9. Report of the Executive Vice President
10. Report of the Kentucky Physicians Care Operating Committee
11. Report of KMA Physicians Services, Inc
12. Report of the Kentucky Medical Insurance Company
13. Report of the Membership Committee
14. Report of the EMCK Foundation

Resolution D — KMA Legal Trust Fund
(Board of Trustees)
Resolution I — Provider Tax Protest
(Jefferson County Medical Society)
Resolution J — Provider Tax Credits
(Jefferson County Medical Society)
Resolution P — Expanded Indigent Care by Kentucky Physicians
(Fayette County Medical Society)
Resolution Q — Inclusion of Sleep Medicine in AMA Codes for Self-Designation
(Fayette County Medical Society)
Resolution U — Medicaid
(Board of Trustees)

ITEMS FOR CONSENT

Reference Committee No. 1 reviewed the following items and recommends they be filed, by consent of the House, without discussion:

3. Report of the President-Elect — filed
4. Report of the Speakers, House of Delegates — filed
6. Report of the Secretary-Treasurer — filed
7. Report of the Editor — filed
8. Report of the Delegates to AMA — filed
9. Report of the Executive Vice President — filed
11. Report of the KMA Physicians Services, Inc — filed
12. Report of the Kentucky Medical Insurance Company — filed
13. Report of the Membership Committee — filed
14. Report of the EMCK Foundation — filed

Mr Speaker, Reference Committee No. 1 recommends adoption of the Consent Calendar as a whole.

Report of the President-Elect

It is my privilege to report to you as President-Elect. In this capacity I have had the opportunity to be exposed to almost all of the activities of the Association and have been pleased to be able to work firsthand not only with the other officers, but with Board members, staff, and many other physicians around the state. This has been particularly enlightening and rewarding.

Legislative activities have dominated this year's work, and the Quick

Action Committee — consisting of the President, Board Chair, Secretary-Treasurer, and Legislative Chair — has met frequently and intensely, and I think with great effect, to meet and dispatch each critical issue that arose. The work of this group and the Executive Committee has been nearly interminable. Likewise, I have been truly impressed by all of the work of many individual physicians across the state on legislative issues.

HB 250 was the focal point of our legislative effort. You have received numerous communications about this legislation and its unsavory provisions. It is interesting to realize, though, that the bill provided some positive outcomes, also. Among these were some much-needed reforms, such as insurance renewability, limits on preexisting condition exclusions, and modified community rating.

In the area of medical education, HB 250 emphasized the state's critical shortage of primary care physicians by calling for family practice residency programs in community sites in each congressional district; an increase in the number of family practice residency positions; a loan repayment process for primary care providers locating in shortage areas; and a physician respite program to relieve those practicing in underserved areas. There were other notable legislative successes which may have become overshadowed by the difficulties we have confronted, but were very positive accomplishments nonetheless.

As President-Elect, I was designated this year to chair the new Physician Organization Committee, which is taking a detailed look at establishing a physician-owned and directed economic entity to act as a vehicle for physician influence in broad-based managed care programs. Unquestionably, managed care will continue to expand, as it is driven by government at all levels and by insurers and large employers. This activity is integrally related to the practice of medicine and our professional future.

We have been fortunate to draw on an array of resources in studying this issue, which have included national consultants, peer organizations across the country, and federal resources. This concept is an area with great potential for further study and activity, and I feel it will become more important to KMA as time goes by. Managed care delivery will likely have a greater impact on the profession and society than any legislation currently being considered.

In the coming year, it would seem that KMA's course is plotted. The passage of federal health system reform legislation is probably imminent, and we will have a major task dealing with implementation of state-level mandates. I hope to devote my efforts and abilities to help play a positive role for physicians in this work and continue the outstanding efforts this year by Ardis Hoven. She has earned the respect of all physicians for her tireless, ceaseless, and effective efforts on our behalf, and she has my deepest esteem.

I thank you for your confidence in choosing me to serve, and I pledge my energy and ability.

Robert R. Goodin, MD
President-Elect

Report of the Speakers, House of Delegates

Your Speakers would like to welcome you to the 144th KMA Annual Meeting, which is dedicated to the memory of James Wesley Ellis, MD, who was President of KMA in 1914. We have instituted some changes for this year's meeting to accommodate concerns you have expressed and to facilitate the business of our organization.

Last year the House voted to reduce the number of Reference Committees from six to five, and to focus on appointment of younger members for service. Your Speakers gave close attention to these directives this year and, in addition to seeking representation from different areas of the state and with consideration to physician population density, have sought to solicit younger members.

This year there will be some additional activities during the first meeting of the House, which begins at 9:00 AM on Monday, September 19. Following business affairs, we are honored to have as our guest, James S. Todd, MD, Executive Vice President of the American Medical Association, who will provide an update on health system reform. Following a meeting of the Trustee District and KMA Nominating Committees, the House will reconvene for an update on implementation of Kentucky HB 250 on health care reform. We have invited a representative of the newly founded Health Policy Board to provide us with information on this subject, which closely affects our professional lives.

Reference Committees will convene at 1:00 PM, with considerable conversation on policy issues relating to health system reform, and I urge each of you to be in attendance.

On Thursday morning, September 22, beginning at 9:30 AM, an educational seminar on AIDS will be offered for all physicians. This program has been approved by the Cabinet for Human Resources as meeting the mandatory continuing medical education requirements for licensure and is accredited by KMA for two hours of Category 1 CME credit.

We look forward to an informative meeting and will make every effort to accommodate concerns of all Delegates. We are hopeful that this will be a useful opportunity for all Delegates and physician members to voice their concerns and help devise policy to guide our Association. As usual, your Speakers will be available throughout the meeting for immediate assistance or to receive suggestions you might have, and we look forward to seeing each of you.

Danny M. Clark, MD
Speaker, House of Delegates

C. Kenneth Peters, MD
Vice Speaker, House of Delegates

Report of the Secretary-Treasurer

I am pleased to report to you as Secretary-Treasurer on the state of your Association this year. This has been a year of change and challenge for the organization but, fortunately, administrative operations have continued to be conducted steadily and evenly.

Membership has continued to grow thanks to the support of Kentucky physicians and the steadfast work of the Membership Committee. Active membership this year exceeded year-end levels from 1993, with a focus on young physicians, and efforts were made to retain and assist members through practice management workshops and member services.

This year the Board of Trustees welcomed new members Timothy K. Hulsey, MD, Bowling Green, 6th District, and G. Irene Minor, MD, Berea, 11th District.

The support of the membership this year was overwhelming in legislative activities, which are addressed indepth in other reports. I think it is important to note the aggressive legal action undertaken on your behalf regarding the provider tax and the fact that this legal challenge continues as of this writing. This advocacy is a very important mission of KMA, and the commitment of the Association to this advocacy will not abate. As other health system reform issues arise, they will be carefully examined to see if further challenges are warranted. Our legal efforts were directed against legislation, but it is a logical assumption that provisions arising from the Jones Administration through the Cabinet for Human Resources might well constitute motivation for other challenges.

While legislative issues at both the state and national level highlighted KMA's work this year, accomplishments were made in other areas that are of commendable note. The Association's continuing medical education accreditation program has expanded its activities in response to an increased demand for local CME offerings, spurred in part by the mandatory CME requirement. This requirement was instituted at KMA's request and is a strong signal of the commitment by physicians to professional growth and excellence.

The Public Education Committee, created by the House of Delegates last year, has met often and intensely and is initiating a positive public education campaign about the role of physicians in serving the citizens of our state. The Committee has set a number of tasks to meet this goal. In one effort, the quarterly patient newsletter has been well received by physicians and patients alike.

Officers and staff have conducted a series of seminars on implementing health system reform. These meetings have been conducted across the state. They were informative and well received.

Numerous other efforts have been undertaken this year with positive results, and these are addressed in other reports which you are urged to consider.

I appreciate the confidence you have shown in selecting me to serve, and I am available for suggestions, comments, and assistance at any time. Thank you for your support of our organization.

William P. VonderHaar, MD
Secretary-Treasurer

Report of the Editor

The *Journal of the Kentucky Medical Association* has been devoted to the interests of the medical profession and public health in Kentucky since 1903 and continues to remain a popular and important benefit of membership in the Association. Every endeavor is made to make it attractive, interesting, and worthy of being your flagship publication — the only publication in an ideal position to focus on the entire state medical community.

Ever seeking to stimulate writing by Kentucky physicians and to encourage the medical schools, hospitals, clinics, and guests to contribute to its pages, our publication remains multi-faceted. During 1993 the *Journal* featured 24 original scientific articles representing the efforts of 76 authors; 3 Grand Rounds contributions from the University of Louisville and University of Kentucky medical schools representing 6 authors; and 8 special articles representing 20 authors. Also featured during the year were several socioeconomic articles; a special report from the Maternal Mortality Committee; the Interprofessional Code for the Kentucky Medical Association and the Kentucky Bar Association; and updates on pharmaceuticals available to the Kentucky Physicians Care Program and participating pharmacies in the KPC Program. In addition, a complete preliminary program for the 1993 Annual Meeting, as well as the entire proceedings of that meeting; several insightful contributions by Book Review Author Stephen Z. Smith, MD; Alliance updates; and numerous editorials and letters discussing medical issues of interest to our membership were published.

There were 10 Editorial Board meetings during 1993, and of the 38 manuscripts reviewed, the editors rejected 4 and returned 3 with recommendations for revision, indicating an 82% acceptance rate. Every effort is extended to assure that the information presented by authors is indeed new, unique, or else so insightful as to merit publication. *Journal* articles are selected for their clarity, accuracy, and clinical usefulness to the wide assortment of Kentucky physicians.

The strength of the *Journal* rests with the quality of the people who serve on the Editorial Board. Each of our editors has unique qualities in producing the *Journal*, and I wish to personally thank the other Board members for giving generously of their time: Drs Daniel W. Varga, Scientific Editor; Stephen Z. Smith, Assistant Scientific Editor; and Jannice O. Aaron, Martha Keeney Heyburn, and Milton F. Miller, Assistant Editors.

It was with regret that the Board recently accepted the resignation of William P. Hoagland, MD. Other professional obligations prevented Dr Hoagland from attending meetings as frequently as he felt his commitment required. Dr Hoagland had joined the Board in 1991, and his guidance and support will be missed.

We continue to welcome from our members and the Alliance personalized accounts of their activities and interests. Through reports of notable professional events — ie, awards, appointments, medical missions abroad, obituaries, and other professional events of interest — our readers can stay in touch with their colleagues. Also, the *Journal* is a great tool for broadcasting the points of view of KMA members. We encourage your letters to the editor.

The Editorial Board serves at the pleasure of the Board of Trustees and appreciates its support in allowing us to bring you a *Journal* that keeps membership current on the policies and decisions of the Kentucky Medical Association and Board of Trustees concerning issues facing our profession nationwide as well as locally and to make you proud to be a member.

We take the concerns of our readers seriously. We welcome your advice and counsel. The *Journal* is, after all, your publication.

A. Evan Overstreet, MD
Editor

Report of the Delegates to AMA

I am pleased to report to you on behalf of your Delegation to the American Medical Association. The work of the Delegates is intense, specific, and voluminous.

At each meeting of the AMA House of Delegates, numerous reports and Resolutions are considered. Rather than assigning a numerical value, it might provide a better indication of the volume of material to say that at each meeting over four inches of paper is required to contain all of the items. Every Delegate and Alternate is assigned to cover the material presented in one of nine Reference Committees, and over a period of time becomes quite familiar with or "specializes" in one given committee's subject matter. This provides some depth to our group and quite a degree of expertise.

At each meeting the Delegation is routinely joined by representatives of the Hospital Medical Staff Section, the Resident and Student Sections, our larger county medical societies, and specialty group members. These numbers and the dedication that everyone brings to our group provide for considerable effective discussion on the issues and constitute an erudite, astute, and solid group to represent Kentucky's views in this national forum.

It is gratifying to report, also, that among the Delegation's membership several individuals have been singled out for even further participation in AMA policymaking. Ardis Hoven serves on the AMA Advisory Committee on Group Practice, Bob Goodin is a member of the AMA's Advisory Council on Continuing Medical Education, and Baretta Casey has represented the Resident Physicians Section and served on the AMA Advisory Committee on Women in Medicine. Judy Linger is a member of the RPS Governing Council, Wally Montgomery has played a pivotal role in a multi-state caucus coalition called the Southeastern Delegation, and I have the privilege of serving as Vice Chair of that group.

The major issue addressed by the AMA House this year has been health care reform, and through policy established by the House, the AMA has done an excellent job in representing the profession to the public and to Congress. In addition to sponsoring the Patient Protection Act and antitrust measures in various legislative proposals, the AMA has established basic provisions of health reform legislation which it has stated as necessary for any bill. These issues are: the guarantee of physician input into managed care plan efforts, insurance reform, universal coverage, and tort reform. Just as in the Congress, the Delegates represent disparate viewpoints, but have held fast to agreement on these points. This adherence to a basic course has proven effective and has maintained the clarity of the professional position.

The specific items that the AMA House has addressed this year are truly voluminous and have addressed virtually all aspects of medical practice and medicosocial economics. There are a few areas that are worthy of highlighting in this report. Several efforts were undertaken to repeal provisions of the Omnibus Budget Reconciliation Act of 1986, which makes provision for taxation of providers to supplement state Medicaid funds; to reform the Clinical Laboratory Improvement Act; and to revise OSHA requirements. Considerable attention was given to continuing education and the need to increase the number of primary care physicians, and anti-tobacco measures were supported, in line with AIDS and other public health matters.

Of some significance was a long-range effort instituted to study and suggest revisions to the medical federation and medical associations to improve their efforts on behalf of the profession and advance service capabilities. Officers and staff of KMA were named to participate in this study committee, and it is anticipated that improved advocacy for physicians will result.

An ongoing concern has been membership issues. In Kentucky, only 50% of eligible physicians are AMA members. In some districts this figure falls below 50%, and in one area as low as 26%. There is no question of the effectiveness and capabilities of a unified voice for the profession through the AMA. It is my firm conviction that one of the many reasons that onerous provisions of health care reform have not progressed further than they have has been the strong influence of the AMA. Few physicians will ever agree universally with AMA policies, but they are the result of a consensus of disparate views, and do represent the majority of physicians' philosophy. A lack of participation in the AMA is tantamount to a lack of participation in the future of medicine.

I would like to take this opportunity to thank each member of the Delegation and those who have participated in its meetings, the Board of Trustees for its support of our work, and the House of Delegates for allowing us the honor to serve.

Donald C. Barton, MD
Senior Delegate

Report of the Executive Vice President

I can state categorically that during my 32 years of service to KMA, the 1993-94 year was the most difficult. Not only did we grapple with courts over legislation adopted by the May 1993 Special Session, we also had to deal with the regular 1994 Session and an Extraordinary Session in June 1994.

We literally endured a crisis orientation from the day Ardis Hoven was sworn in to this very moment. Unfortunately, Robert Goodin, our President-Elect, will experience an equally engrossing year as we face the onslaught of regulations which are sure to come to implement health system reform, Fraud and Abuse, Workers' Compensation, and other legislation relating to advance directives and Board of Licensure changes.

While other reports, including the Board Chair, State Legislative, and other committee and officer reports will deal with the 1994 Session of the General Assembly and resulting activity, it is appropriate that comments be made on the KMA officers who dealt day in and day out with the Frankfort morass. Perhaps in no other time in the 143-year history of the KMA has the profession faced such a full scale assault — often an assault to simply be punitive to physicians if for no other reason. If ever there was a time when we needed strong leadership, 1993-94 fits the bill.

As I have said more than once, Ardis Hoven was the right person in the right place at the right time. Dr Hoven guided us through many difficult days and received many plaudits for her testimony before committees in the General Assembly. She always had the facts, knew KMA policy, understood the options, and clearly and succinctly expressed medicine's concerns. Legislators, both friend and foe, commented on her outstanding ability to articulate physicians' positions, particularly as they related to patient care. Her effectiveness was perhaps most notable within. In times of difficulty, individual members had legitimate differences as we debated which direction to take. Let me assure you that we all labored with the knowledge that decisions made, in many cases requiring a decision in hours, would impact every physician in the state. On numerous occasions, it was Dr Hoven's quiet reflection and willingness to accept responsibility and results of our joint decisions which permitted us to remain united and stay on course.

Year after year, I have commended Wally Montgomery, our legislative chair, for keeping us on track during legislative sessions. Dr Montgomery's experience, indepth planning, and willingness to sacrifice his time and give truly of his talents on behalf of Kentucky medicine are unprecedented. All of us owe him a deep sense of gratitude. Board Chair Don Stephens received his first taste of legislative combat, and we were impressed with his strong positions, and particularly the rural physician's perspective he brought to the table. President-Elect Bob Goodin brought immense knowledge relating not only to scientific segments like practice parameters, but strong data on the socioeconomic aspects of medicine. Dr Goodin was a tremendous resource to the group and was a great team player. Few presidents have ever come into the office better prepared. Secretary-Treasurer Bill VonderHaar's excellent knowledge and understanding of primary care's role in health system reform contributed greatly. He is always there and he is solid. Finally, special thanks to Bill Monnig, Immediate Past President, and Russell Travis, Immediate Past Chair of the Board, for hanging in there and lending their expertise and experience.

While we were engaged in battle with the General Assembly on the state level, AMA has been waging an all out war with Congress and the Clinton Administration on the national level. Former House Chairman of the Ways and Means Committee, Dan Rostenkowski, called the Clinton health system reform "the domestic equivalent of star wars." Most physicians are busy with their practice and often are unaware of AMA's activities on their behalf. Unfortunately, less than 50% are members of AMA and this somewhat hinders the federation's efforts. However, the AMA has been superb and many congressional watchers have been complimentary of AMA and its lobbying effort. Several notables have attributed Clinton's inability to get his plan adopted to the AMA. All physicians owe it to themselves, the profession, and those who follow to belong and participate in AMA. The AMA is the only representative of the body of medicine and the only group that truly represents all types of medical practice in Washington.

We are pleased to report that active KMA membership is at an all-time high. Total KMA membership, including residents, students, and retired physicians is 6,068 as of mid-August. Year-end figures should increase another 100 or so. We believe that membership increases confirm and support KMA leadership struggles, particularly against the provider tax and the ordeal of the 1994 Session of the General Assembly. Sincere thanks to those of you who stayed the course and occasionally gave us a pat on the back for our efforts. The lift you gave us during the darker days of the Session will not be forgotten.

In this report we will not go into the court challenge of the provider tax. The Board has pursued all legitimate and reasonable efforts through the court system. Because of various loopholes and legal maneuvers that permit the courts and legislators to cloud the issues, it seems the only way we will ever truly overcome the tax is through repeal. While we will make every effort to seek repeal, the campaign will require grass-roots support if we are to be successful. The KMA Board of Trustees has been outstanding this year. The Board has been faced with tremendous challenges and, in turn, they have been a very cohesive unit and come to good-sense conclusions, resolutions to problems, and directives for officers and staff.

The various entities established by KMA to provide support services had an outstanding year. KEMPAC, the political arm of medicine, while not reaching its record membership of 1992, had a wonderful year under Chairman James D. Crase, MD, of Somerset. Dr Crase has started a process whereby KEMPAC will be working toward educational programs to assist physicians in getting involved in politics at the grass-roots level, plus teach them to work within the political arena to achieve defined goals.

The Rural Kentucky Medical Scholarship Fund (RKMSF), organized by KMA almost 50 years ago, continues to grow and assist rural communities in obtaining medical services. There is approximately $1 million in the fund and the Board of Directors continues working toward new programs to assist Kentucky's rural and underserved areas. While the General Assembly and others start new programs, most are facsimiles of the RKMSF.

The KMA Alliance has had an outstanding year and we congratulate Gloria Griffin, 1993-94 President, for her labors. We look forward to working with 1994-95 President Joyce Clark of Somerset in various areas of mutual endeavor to enhance the relationship between KMA and the Alliance and to build on our past. We are very pleased to learn that JoAnn Daus will be installed as President of the Southern Medical Association Auxiliary on November 4. This is a tremendous honor for Kentucky. JoAnn, a former Alliance president, is well known around KMA. We are extremely happy for her and the honor she brings to our Alliance.

The Impaired Physicians Committee, under the direction of Burns M. Brady, MD, has done an outstanding job. With the formation this year of the Kentucky Physicians Health Foundation and, as a result of legislation cosponsored by the Board of Medical Licensure and KMA, the Committee will fall under the auspices of the Foundation and have closer ties to the Board of Medical Licensure. The legal protection and official support the Committee achieves under the aegis of the Board of Medical Licensure will make its work far more effective in its day-to-day efforts to assist physicians who encounter various personal and medical problems which affect their medical practice. Mark F. Pelstring, MD, member of the KMA Board of Trustees, has assumed the Chairmanship of the Foundation and Dr Brady has been named Medical Director. Kentucky physicians owe a great deal of thanks to Dr Brady for his hard work and extraordinary vision. Despite the fact that the Committee is no longer a component of KMA, we will continue to support its efforts in every way we can.

Kentucky Medical Insurance Company has once again achieved an A- rating from A.M. Best, Inc, the organization which traditionally grades insurance companies on their management, business practices, reserves, etc. The KMIC Board, under the chairmanship of Richard F. Hench, MD, and the day-to-day operations of Steve Salman, CEO, continues to provide security for physicians in Kentucky, maintain the professional liability market at reasonable rates, and assure coverage for Kentucky physicians.

We all know that professional liability insurance companies, including KMIC, face a rapidly changing environment. To meet the demands of the future market, KMIC must change.

As you recall, KMIC was formed in the mid 70s to (1) provide a stable, competitive market for physicians' professional liability coverage, (2) be there in the event of another crisis, (3) be physician controlled and managed. Those of us who experienced those difficult days never want to return to those excruciating times. Malpractice insurance was unavailable to many physicians and, in fact, threatened the delivery of medical care in some communities.

To rectify this problem, we went to the General Assembly and successfully adopted a tort reform package that equaled or bettered the present Indiana reform laws. However, the court threw out our package and we were back to ground zero. That is the climate in which we found ourselves in 1977 when the decision was made to form KMIC. Without KMIC we would have experienced that very same crisis in the mid 80s when KMIC was essentially the only medical liability insurer in the state.

Malpractice crises are cyclical, historically occurring about every 10 years. Fortunately, KMIC's presence in Kentucky has kept the medical professional liability insurance market stable despite the ups and downs in the malpractice cycle. KMIC has upheld its pledge to serve Kentucky physicians regardless of the liability environment.

And now, KMA and KMIC are planning for the *future* liability environment — an environment that includes rapid consolidations among providers, the need for a broader product line and, in general, a bigger and stronger insurance company.

KMIC has said that partnerships with other companies are the best solution to meeting the needs of this rapidly changing healthcare market. Furthermore, by forging partnerships with other companies, KMIC will be in a better position to continue to provide a stable liability environment in Kentucky. The KMA strongly supports KMIC's direction.

Such partnerships or business combinations should bring excellent benefits to Kentucky physicians. The financial clout to meet future liability demands, regardless of the claims environment, is absolutely essential. Furthermore, an expanded product line will be increasingly important as healthcare providers form unique organizations and are faced with a myriad of changes in the healthcare delivery system. And finally, as large provider groups cross state boundaries, it is important that we have an insurance company that offers insurance in a multi-state area with satellite locations.

But seeking alliances with other companies is only a first step for KMIC. I expect to see *many* positive changes at our insurance company in the coming months. These changes are both healthy and appropriate in this environment of rapid change in the insurance and healthcare industries.

Speaking of change, it is likely that more changes will take place in KMIC's corporate structure. For example, as KMIC grows, you will most likely see an increase in the company's size and financial strength as well as a greater diversity of products and services. Additionally, it may be necessary to modify the stock structure of KMIC as the company seeks collaboration partners.

Liability insurance is important to all of us. We cannot allow such an important service to slip away simply because we failed to adapt our insurance company to a changing environment. Therefore, we will work with KMIC to further position the insurance company to serve the long-term needs of Kentucky physicians. Our foremost objective continues to be to insure that Kentucky physicians have a stable and reliable source of liability insurance.

The KMA will continue to foster closer ties with KMIC. It is part of our service to Kentucky physicians to provide an environment in our state that enables physicians to practice medicine without the fear of ruinous litigation. KMIC makes this environment possible. We hope that our members will support KMIC as it evolves to meet tomorrow's market.

KMA is extremely proud of all of its affiliated organizations and continues looking for different ways to serve members and enhance the medical profession of Kentucky.

The Association remains financially strong. Continued oversight of our financial operation by the Budget Committee and daily efforts to minimize expenditures and increase income by staff have allowed us to stretch our five-year dues plan to an expected ten-year cycle, at least.

The KMA Headquarters Office has just over two years remaining on our current lease. The Board of Trustees has authorized a continuing lease plan either at our present location or elsewhere, if indicated. Negotiations are already underway in this regard.

The KMA staff members are very special people. They are a joy to be around and their work ethic is unmatched. Some are generalists, some are specialists, and they all blend together to create a very finely tuned machine. They know what they are doing and they do it well. They work long hours. They work hard. I am proud to be a part of their team. In addition to their knowledge and determination, our staff brings over 300 years of KMA experience to their assignments. I want to openly thank each of them for their efforts and achievements this past year.

Unity within the federation is paramount if medicine is to retain its role. The federation, composed of county, state, national, and specialty groups, has never been more important. So-called reformers on both the state and federal level have tried in every way they can to reduce the influence of physicians and break the sacred patient/physician relationship. Our Public Education Committee is addressing this bond and is making headway in developing ties with patients. However, it is incumbent upon every physician to take the time and make the effort to seriously review office practice procedures to determine if your office is "patient friendly." This review could be as important to the financial aspect of your medical practice as a review of your legal or financial controls. In the near future, as health insurance companies, government, entrepreneurial providers, and others develop strategies to control patient access to medical care, the only obstacle to taking over this segment of our economy is the patient's objection to plans which remove their choice of physician. We plan to help strengthen that tie but its success or failure will be determined by you in the end.

Thank you for the opportunity to serve and for your individual contributions. They were especially noticed this year. We look forward to a productive year under the leadership of Dr Goodin.

Robert G. Cox
Executive Vice President

Report of KMA Physicians Services, Inc

KMA Physicians Services, Inc, is the only wholly owned subsidiary of the Kentucky Medical Association, and serves as a holding company to its own subsidiary, the KMA Building Corporation.

The KMA Building Corporation was formed when we owned our own headquarters building, which was sold in 1991 to Hospice of Louisville, Inc. The Building Corporation received the proceeds from the sale of the old headquarters building and transferred them to KMA's building fund for future use. The KMA is currently leasing space with a lease agreement lasting through 1996. A committee is studying criteria for a future home for KMA.

Don R. Stephens, MD
Chair

Report of the Kentucky Medical Insurance Company

Highlights

KMIC's A M Best rating of A- (Excellent) was reconfirmed for 1994. This high rating is based on KMIC's financial strength and strong reserves.

On January 1, 1994, KMIC instituted the first policy rate increase in four years to prepare for rising claims and claims costs. Also, the Physicians Experience Pool credit was eliminated. Despite these changes, KMIC has renewed over 91% of its physician business. Premiums written for new business have increased.

In fact, three new, large policyholder groups joined Kentucky Medical during 1994. These new accounts include:

- a group of 29 nursing home and subacute care facilities
- a large and prestigious group of Louisville physicians
- a Northern Kentucky/Southern Ohio organization that includes seven physician groups

Claims costs continue to climb. The company is taking positive steps to control claims and claims expenses. For example, KMIC continues to aggressively defend its policyholders. At midyear, 20 out of 22 trials had been tried and won. Also, progress is being made in reducing legal defense costs. For example, we are implementing alternative fee structures for our defense attorneys.

KMIC's Continuous Quality Improvement Program is going strong. Two teams have been formed to further improve internal processes. Also, a survey mailed to all of our insured physicians will help us refine our products and services to meet the needs of physicians not only today, but also tomorrow.

Opportunities

KMIC sees the future as a world of opportunity. To take advantage of those opportunities, Kentucky Medical is positioning itself for tomorrow's market. That's why collaboration remains a top priority. Through collaboration KMIC can more quickly and effectively meet its growth goals and offer customers an even broader array of products and services.

As most Kentucky physicians already know, KMIC has made collaboration with other companies a high priority. Many contacts have been made with other companies. The company will continue to work toward collaboration.

The healthcare facilities market is outpacing growth in the physician business. In fact, from 1992 to 1993 the Hospital Division had a 40% increase

in revenues. This growth is expected to continue. To sustain and encourage these positive results, KMIC has allocated additional resources to the Hospital Division. Most notable is the addition of Randolph Gore as Vice President of the Hospital Division. Gore joined the company September 1, 1994.

Kentucky Medical will continue to grow and diversify its subsidiary operations. The company is currently seeking partnerships for its insurance brokerage business, the KMA Insurance Agency. Further, the company continues to support the growth of United Leasing, its largest subsidiary.

Concerns

The frequency of medical malpractice lawsuits continues to increase. Even though this stage of the insurance cycle was anticipated, Kentucky Medical is uncertain just how long this harsh claims environment will persist.

Other concerns for Kentucky Medical include intense price competition in our market area and lower interest rates in the investment marketplace.

Conclusion

Despite rising claims costs and declines in investment income, Kentucky Medical is poised for the future. Our product flexibility and experience with healthcare facilities are definite assets as healthcare reform evolves.

KMIC has upheld its obligation to keep Kentucky's medical professional liability market stable and reliable. Through our financial strength and integrity, we will continue to serve Kentucky physicians in this manner.

Richard F. Hench, MD
Chair

Report of the Membership Committee

Although the Membership Committee did not meet on a formal basis this year, the recruitment and retention of physicians, residents, and medical students in this Association have continued in an ongoing and productive manner. Members of the Committee have been informed of current activity and provided with a demographic study of membership for their suggestions on future programs.

Year-end 1993 membership figures revealed an excellent increase in almost every category. Active members reached an all-time high of 4,101, a net gain of 155, or 4% over year-end 1992. We were pleased to continue this upward spiral on the heels of KMA's best membership year ever in 1992, noting an almost 10% growth in the Active category in a two-year period. Total KMA membership in all categories, including Life and Students, was 5,995 at year-end 1993.

Excluding the loss of 150 Active members who left the state, retired, or died, the Committee is pleased to report that 98% of 1992 members rejoined in 1993. In addition, 326 new Active members were recruited in 1993, along with 102 new In-Training, and 20 new Associate members. The addition of 70 residents who took advantage of the free six-month membership offered at Housestaff Orientations in June brought the total new members for 1993 to 518.

We have continued to experience growth in 1994 and are pleased to report that as of June 30, 1994, we have already exceeded year-end 1993 in the Active category:

Membership Category	# as of 6/30/94	# as of 12/31/93
Active	4,107	4,101
In-Training	254	288
Associate/Inactive	253	256
Total Dues-Paying	4,614	4,645
Total KMA All Categories	5,832	5,995

Extensive demographic studies of members and nonmembers have been conducted for the past several years in an effort to note trends and areas in which we must concentrate our efforts. The 1994 Demographic Study was forwarded to each KMA Trustee asking them to increase their efforts to involve more physicians in organized medicine. We would like to particularly recognize Second District Trustee John W. McClellan, MD, for his work in recruiting ten new members this year.

Since membership development became a full-time function of the Association in 1984, we thought it might be of interest to compare some demographics from that time:

Membership Category	1994	1984	Increase
Active	4,107	3,344	+ 23%
In-Training	254	112	+125%
Life Members (Dues Exempt)	621	345	+ 80%
Total KMA Members	5,832	4,018	+ 45%
# Nonmembers Active-Eligible	1,503	1,506	—
# Nonmembers Under Age 40	554 (37%)	1,100 (73%)	− 36%
# Nonmembers Women MDs Under Age 40	166 (30%)	209 (19%)	+ 11%
# Nonmembers Under 40 (Primary Care)	296 (53%)	550 (50%)	+ 3%

Due to the commitment of the Membership Committee and Board of Trustees to target young physicians during this ten-year period with a number of specific recruitment efforts, ie, videotape, phonathons, liaison with medical students and residents, peer-to-peer programs, and letter-writing campaigns, it is evident from the figures above that the Association has been successful in enlisting this age group as they finish training and enter practice in Kentucky. We do recognize the need, however, to continue to target this age group as well as women physicians and primary care specialists in our recruitment efforts.

The membership recruitment plan for 1994 included five statewide mailings, seven campaigns targeted to specific groups, and two peer-to-peer outreach programs, for a total of more than 7,000 individual contacts. In addition, routine contacts are made on a daily basis to physicians new to the state or just starting practice.

It is also evident from our tracking of new members that the most effective way to convince a nonmember to join is through a personal contact by another physician. The Committee recognizes Arthur Rivard, Jr, MD, Danville, for his successful recruitment efforts in Boyle County in the "Member-Get-A-Member" outreach program initiated at the 1993 KMA Annual Meeting.

Although recruitment is a major part of membership development, retention of members is also of extreme importance. The 1994 Demographic Study revealed that one-third of all nonmembers were once KMA members. In some Trustee Districts, this figure is as high as 50%. Our retention program begins with billing in mid-October, followed by at least five follow-up mailings and additional phone calls and personal contacts by Trustees, county society secretaries, and KMA staff. The "Superbill" program initiated in 1992 will be expanded from four clinics to almost 16 clinics and large groups for the 1995 billing. This efficient manner of billing individual members on one dues statement to a clinic or group administrator has proven to enhance not only retention but also recruitment of new physicians to the group.

KMA continues to support activities to involve residents and medical students in organized medicine. Almost 100 new residents were recruited during the Housestaff Orientations held June 27 at the University of Kentucky and June 30 at the University of Louisville. The Committee wishes to thank Judy M. Linger, MD, KMA-RPS President, and Joseph E. Kutz, MD, KMA Trustee, for representing organized medicine at this year's programs.

KMA student leaders at both medical schools received awards at the AMA Interim Meeting in December for their recruitment efforts, netting 108 new student members (29 at UK, 79 at UL). Currently, 72% of Kentucky's medical students and 25% of residents are KMA members. Both the RPS and MSS are involved in membership recruitment efforts to increase participation.

As a service to its members, the Membership Committee sponsored eight practice management workshops (12 individual sessions) during 1993-94 with a total attendance of almost 400 physicians, spouses, and office personnel.

On behalf of the Membership Committee, we urge every member to help us in building a stronger membership base so that the Association can successfully fulfill its mission of service to the profession and to the public.

Harold D. Haller, Sr, MD
Chair

Report of the Ephraim McDowell Cambus-Kenneth Foundation, Inc

The Ephraim McDowell Cambus-Kenneth Foundation, was incorporated on May 26, 1988, as a not-for-profit Kentucky corporation and exists exclusively

for "charitable and educational purposes in promoting an appreciation of history through the acquisition, restoration, and preservation of buildings and properties having special historic significance."

The Foundation was formed by the Kentucky Medical Association for the purpose of accepting from Mr Joe A. Wallace and Mrs Cecil Dulin Wallace, upon their deaths, the 550-acre Cambus-Kenneth Farm located in Danville. As many of you know, Mr Wallace passed away in late 1992. Today, the Farm remains with Mrs Wallace, recipient of the 1993 KMA Award. The Cambus-Kenneth Farm was owned at one time by the pioneer physician, Ephraim McDowell, MD; served as his summer home; and was the site of his death. Additionally, the assets of the former McDowell Memorial Fund, including the McDowell House and Apothecary Shop, also located in Danville, were conveyed to the Foundation by the Kentucky Medical Association.

The Foundation's Board of Directors met on September 30, 1993, and elected the following corporate officers for 1993-94: Ardis D. Hoven, MD, President; and William P. VonderHaar, MD, to a combined office of Vice-President and Secretary-Treasurer. Other members of the Foundation Board include John W. McClellan, MD; Scott B. Scutchfield, MD; G. Russell Shearer, MD; and David W. Kinnaird, MD as an ex-officio member.

The McDowell House Managers Committee operates under the auspices of the Foundation to supervise the maintenance and operation of the McDowell House and Apothecary Shop. A report on the financial status of the McDowell House will be presented to the Foundation's Board of Directors at its annual meeting in September. However, finances seem to be in good order. The Managers Committee is placing additional emphasis on the "Friends of the McDowell House" project in an attempt to increase the number of Friends and to increase donations. The Managers Committee continues to meet on a quarterly basis, and its Chair serves on the Ephraim McDowell Cambus-Kenneth Foundation Board of Directors.

The Kentucky Medical Association Alliance has continued to play an important role in maintaining and adding to the collection of the McDowell House and has been very faithful in its participation.

The Foundation's Planning Committee continues to meet regularly with Mrs Wallace to explore its options and opportunities when the Farm is conveyed to the Foundation.

The Foundation Board would like to thank Russell Shearer, MD, Chair of the McDowell House Managers Committee, as well as the Committee members, McDowell House staff, and volunteers who have made the operation of the Foundation a success during the last year. I would like to express my personal appreciation to the other members of the Foundation Board for their service this year.

Ardis D. Hoven, MD
Chair

END OF CONSENT CALENDAR ITEMS

Report of the President

It has been an honor and a privilege to serve the Kentucky Medical Association as its 143rd President in a year which has been incredibly important to the profession of medicine. In my original address to the KMA I urged unity within the profession and active advocacy for the patients whom we serve. The commitment of physicians to these ideals has been very gratifying and has continued throughout the legislative activities of the year, through litigation of the provider tax, and even now through the crush of changes being considered by the Cabinet for Human Resources. I applaud you, the membership of KMA, for your dedication and willingness to commit your resources, your valuable time, and your spirit!

Multiple *challenges* have characterized the activities of the year and will continue through the coming year. The provider tax litigation began July 1993 when the KMA filed suit in Franklin County Court, and in November Franklin Circuit Court Judge Roger Crittenden determined that certain provisions of House Bill 1 detailing the provider tax were unconstitutional. However, on March 24, the Kentucky Supreme Court overturned the prior decision and held that the health care provider tax was constitutional. As of this report, your Board of Trustees has voted to proceed with litigation at the Federal Supreme Court level. The impact of your participation in speaking out against the tax and the inappropriate Medicaid funding issues espoused by state government has been extensive and speaks strongly for your commitment.

During the first week of January 1994, the Kentucky General Assembly convened and began its deliberations on health system reform (HB 250) and completed its activities in April. The initial components of the reform legislation encompassed rate setting, prescriptive authority for ARNPs with independent practice, prescriptive authority for optometrists, inappropriate self-referral language, voluntary arbitration and mediation, and the provider tax. Many changes were effected in this legislation and many of the more onerous elements were removed through the dedicated efforts of the Quick Action Committee and our highly effective lobbyists. KMA staff and leadership worked diligently through this entire process on your behalf, taking every opportunity to influence changes in a positive and productive manner.

The challenge continues now as the regulation-writing process for implementation of this legislation moves ahead. During this session, multiple other bills were followed and discussed. However, most of our efforts were devoted to HB 127 and SB 37 (Medicaid Fraud and Abuse), HB 928 (Workers' Compensation), SB 177 (Medical Licensure/Impaired Physicians), and SB 311 (Advance Directives).

It is vitally important that we continue to challenge, debate, and influence the problems which face medicine in the months to come. Medicaid funding remains of considerable concern, with intended significant cuts in reimbursement and the addition of greater numbers to the rolls without consideration by government as to the implications for the viability of the Medicaid program and retention and recruitment of physicians in the state.

The delivery of health care and the planning required to deliver health care in this state need to remain in the capable and caring hands of the physician community. It is imperative that we continue to pursue changes in tort reform and press for a constitutional amendment that will allow a noneconomic damages cap. It is likewise crucial that the "Fraud and Abuse" legislation be implemented in such a way as to alleviate the problems that we know exist, not simply punish physicians who care for the indigent.

The list of challenges will continue to grow and change in configuration; but with the greatest of confidence, I know that under the able direction of Dr Robert Goodin, continued success will be achieved.

I would be remiss if I did not acknowledge the devoted and very capable staff of the KMA under the direction of Mr Robert Cox, our Executive Vice President. It has been an incredible opportunity being associated with these dedicated and always encouraging people!

My thanks to you, the members of the Kentucky Medical Association, for the honor bestowed upon me as President of this organization and for the opportunity to serve.

Ardis D. Hoven, MD
President

Recommendations, Reference Committee 1:
Mr Speaker, Reference Committee No. 1 reviewed the Report of the President. The Committee would like to express appreciation to Doctor Hoven for the fine work she has done over the past year and her excellent representation of medicine. We salute the path she has forged as KMA's first woman President and hope more women physicians will become involved in leadership positions.

Reference Committee No. 1 recommends that the Report of the President be filed.

Report of the President, Alliance

The focus of the 1993-94 Alliance was twofold this year. Responding to our members' recommendation to concentrate our efforts on one statewide health education focus, our members overwhelmingly stated that their priorities were on "Kentucky's Youth . . . Our Future," and educating physician spouses about the effects of the impending health systems reform.

The 1,094 Alliance members throughout the Commonwealth responded to the challenge of working on projecting a strong image of medicine throughout their communities. Leadership responded to our members' desire to develop a statewide health focus that would be continued for several years. Our members overwhelmingly requested that the Alliance focus on Kentucky's youth. We provided a comprehensive "Kentucky's Youth at Risk" conference in the fall dealing with issues that are affecting the future of our youth in Kentucky.

Our members are the invisible workers and planners in your communities and they have continued to represent medicine in a positive, united

front, working in coalition with schools, churches, civic groups, and community agencies. With these physician spouses volunteering their hands and their hearts, we focused on Kentucky's youth at risk. Anti-smoking campaigns were implemented in Bowling Green and Lexington, providing programs to reach our youth regarding the hazards of smoking. In Owensboro, "Project Parent" was implemented, a community-wide campaign to encourage effective parenting. In Paducah, our members organized a project to revitalize two dilapidated playgrounds in the city. The in-training spouses focused on projects to help children in a cancer ward and their families at the Ronald McDonald Houses.

The Kentucky Medical Association was enhanced as Alliance members worked to implement grass-roots legislative efforts in every organized county. The KMA phone bank was reactivated and was manned by Alliance members from Fayette County. As the session drew near, all counties with an organized alliance were asked to develop a phone bank and we were instrumental in activating physicians and their spouses across the state regarding the impending legislative issues. Our members spoke to community organizations, worked phone banks, and participated in workshops on "How to Speak to Your Legislator" and "What Health System Reform Will Mean To You Personally." During the Legislative Session, members visited with their legislators on numerous occasions, tracking the voting records of their legislators and calling when their representatives voted against medicine.

The support of the KMA and the positive promotion of the Alliance by KMA leadership have been invaluable and have allowed the Alliance to continue to provide Kentucky physician spouses with quality programs and projects. I appreciate the encouragement and the continued support the Alliance receives from the Kentucky Medical Association leadership and staff as we work together to achieve the KMA Alliance mission, "to work in coalition with the KMA to promote quality health care and sound legislation."

Leadership training was available for state officers and convention delegates at national meetings. AMAA provided two occasions for our county presidents-elect to gather information to help them better serve their communities. Last year county presidents-elect from Boyd, Daviess, Fayette, Jefferson, McCracken, and Pulaski Counties, and Northern Kentucky, were given the opportunity to travel to Chicago for intense training, since future generations will be leading this organization in just a few years.

Leadership provided information and assistance to counties in their efforts to increase membership, to raise funds for medical education through AMA-ERF, to promote health and healthy lifestyles, and to stay informed on legislative activities. Our board members kept the membership informed of the activities at the McDowell House, the needs of the Ronald McDonald Houses, and special projects involving Medical Heritage and Doctors' Day.

We are proud of why we are an organization . . . our special bond to Kentucky's future in medicine . . . OUR marriage to a physician. The KMA Alliance needs the financial support of all physician spouses in Kentucky. The commitment of our members is evident in the projects I just mentioned, but the Alliance could accomplish more for organized medicine by just increasing its dues-paying membership.

In closing, just 16 months ago I challenged physician spouses to commit to the medical profession with the same dedication as their spouses; to serve that commitment by urging significant activities by their organization at the local, state, and national levels; and to then become personally involved in those efforts.

I would like to challenge each of you here to sign your spouse up as a member of the Kentucky Medical Association Alliance. The Alliance is a valuable asset of the Association, and we need the support of one another in order to survive.

Gloria J. Griffin
KMAA President
1993-94

Recommendations, Reference Committee 1:
Reference Committee No. 1 reviewed the Report of the President, Alliance, and wishes to thank Gloria Griffin for the leadership of physician spouses in Kentucky.

Reference Committee No. 1 recommends that the Report of the President, Alliance, be filed.

Report of the Chair, Board of Trustees

Introductory Comments

A major challenge to your Chair each year is to describe the effort made by the Association on your behalf over the past 12 months. This year that task was even more difficult because of the extraordinary issues with which KMA was confronted. The reform of our delivery and payment system moved ahead in the private and public sectors. The Board gave thoughtful consideration and sometimes held spirited discussions about reform and the role organized medicine should play in the transformation.

Legislatively driven reform measures generated in Frankfort and Washington, DC, dominated our lives. While this year's legislative battle in Frankfort is over, the regulatory struggle is just beginning and much of the structure of reform in Kentucky will be crafted in that process. Nationally, as this is written, the debate continues with little consensus among the five committees with jurisdiction over reform and the various interests represented in Congress.

The Kentucky General Assembly convened with a priority on radical reform of Kentucky health care delivery and payment structure. The Legislature, embarrassed by its failure to produce any real health care reforms during a costly Special Session held to deal only with that issue, and still reeling from an ongoing federal investigation, was determined to produce something it could call reform. The administration, frustrated with its inability to enact its concept of meaningful reform during the Special Session, was determined to see something passed during what could have been its last chance to do so before going out of office. Mix in the biased exposure from the liberal press and the potential for far-reaching changes was readily apparent.

It is within this context that the results of KMA's actions during the Legislature must be evaluated. And KMA's actions this year were truly those of the membership. Individual members all across the state made their legislators aware of medicine's viewpoint during the session and several county medical societies undertook organized initiatives to persuade their representatives to support KMA's position.

As a result, several onerous provisions failed to be enacted, such as rate setting, mandatory participation in government health care programs, and changes in Kentucky liability insurance law that would have made a bad situation worse.

As Chair of your Board of Trustees, I was privileged and proud to see the support of KMA's membership from every part of the state and every specialty, as we went about our business, especially in the legislative arena. My faith in the process was reinforced as I witnessed the thought, concern, and commitment of the Board of Trustees' democratic decision making on behalf of the membership. I felt privileged to work with the officers on a weekly and sometimes daily basis and marveled at the time and energy spent to represent the best interests of our patients and colleagues. I was proud of our staff members who were relentless in planning their work and working their plan, a dedicated, hard-working group unmatched, in my opinion, by association staff . . . anywhere.

I was especially pleased to serve as your Chair during this term of KMA's first woman President, Ardis Hoven, who could and did handle our affairs this year, as perhaps no other could have done. Ardis Hoven was a quick learner, an effective leader both internally and externally, a superb communicator, and for us was the right person in the right place at the right time. Thank you, President Hoven. We are proud of the job you did and grateful for your commitment, resourcefulness, and assiduity. You certainly made my job easier than it would have been otherwise.

Your Association at Work

We would have liked the outcome of some of our priority issues to have been different. However, those involved in the daily grind certainly know things could have been a lot worse without the hard work of many of you. Using our resources to the fullest extent, the execution of KMA's efforts on behalf of the profession was unparalleled. My thanks go to all involved.

The Kentucky General Assembly met not only in regular session from January through April this year, but also in a Special Session in June. We saw the passage of Senate Bill 311, with strong KMA input in this Advanced Directives/Living Will legislation. Senate Bill 37 and House Bill 127 were the Medicaid Reform Bills incorporating fraud and abuse and self-referral provisions. House Bill 928 was a new Workers' Compensation Bill, and the mother of all legislation for us this year was House Bill 250 on Health System

Reform, which also included the provider tax. I will not elaborate on the details of legislation passed as that will be presented to you in other reports. I do want to take this opportunity to recognize the incomparable work of State Legislative Committee Chair, Wally O. Montgomery, MD. He spent countless hours on the phone with lobbyists, legislators, and members, in addition to driving from Paducah to Frankfort and back every Wednesday. He is truly a faithful, committed, and knowledgeable individual and we are fortunate to have him serve in this key role.

Our preparation and daily production during the General Assembly was unexcelled. Yet, when it was over . . . it wasn't over. Because of the significance of health legislation this year, a series of special seminars were held to advise our membership of the practical effects of health system reform on their practice. Fifteen seminars were conducted around the state, and a 60-page booklet highlighting all these health care system changes was authored, printed, and distributed to seminar attendees as well as any KMA member requesting one. As of this writing, we plan to include one in your Delegate's package.

The meetings required of Association representatives during a session of the General Assembly are mind boggling. Many meetings are held with special interest groups, both medical and nonmedical. Before the Legislature had adjourned, the Legislative Quick Action Committee had met 15 times, the Executive Committee twice, and the Board of Trustees had held a special meeting over and above its routine sessions.

In addition, KMA conducted legislative seminars for our members during the session, the usual Trustee District meetings, CME meetings, and special managed care seminars along with hospital medical staff managed care briefings. We held a special Legislative Day in Frankfort, and as if state activity wasn't enough, we also went to Washington to provide input on national health system reform during meetings with our Kentucky Congressional Delegation. All during one of the worst winters in Kentucky's history.

Yet, we managed to continue all the other Association responsibilities to members and to the public with some 40 committees conducting needed programs and activities. KMA also managed to present eight practice management workshops on topics of special interest to our members. And while the officers and senior staff were totally engaged in these types of responsibilities, the KMA office staff was in the headquarters office working harder than ever to meet deadlines and provide support. Good communications were imperative so the membership could keep apprised of our policies and activities as changes in the political climate required frequent adjustments to our positions. This required the office staff, frequently after hours, to print newsletters and bulletins, and stuff and mail some one-quarter of a million envelopes.

The Provider Tax

The ultimate insult to Kentucky physicians and their patients, proposed by the Governor and imposed by the Kentucky General Assembly, was reenacted as the provider tax this past April. This selective approach to taxation (2% on physicians' gross revenues) is dead wrong. I don't think there is any doubt that our Governor and legislators know that, but they felt it was politically safer to raise taxes on a select few than to enact a broad-based tax to fund Medicaid. Society's problems should be solved by society. KMA fought the tax with all available vigor and it barely passed by two votes. Much has been written about this onerous piece of legislation, so I will summarize a few highlights:

— The provider tax was first passed as House Bill 1 in Special Session in May 1993, to be effective on July 1, 1993.

— KMA immediately filed suit on July 2, 1993, contesting its constitutionality, and the Franklin Circuit Court ruled it unconstitutional on November 23, 1993.

— On appeal, the Kentucky Supreme Court reversed the Circuit Court on March 24, 1994, and ruled the tax constitutional on a 5-2 vote, with three special judges appointed by Governor Jones voting in the majority.

— On April 13, 1994, KMA filed Petition for Rehearing requesting the Kentucky Supreme Court to reconsider this case.

— The Supreme Court of Kentucky denied the Petition for Rehearing without a dissenting vote on June 23, 1994.

KMA will continue to pursue House Bill 1 through appeal to the United States Supreme Court. It was the opinion of the Executive Committee on July 21 and the Board of Trustees on August 10-11 that further pursuit was indicated and would be responsible even though the odds are not weighted on our side.

Our chances to be heard by the US Supreme Court are admittedly slim. If heard, overcoming tremendous odds to rule in our favor would be required as the 14th Amendment of the US Constitution does not favor our case, while Section 59 of the Kentucky Constitution seemed to do so. (Our plan for success was heavily dependent on the Kentucky Supreme Court.)

We have been advised by counsel that even if we overcome all these odds and win we may not truly prevail, because the lawsuit in question contests House Bill 1, which sunset July 15, 1994. Depending on the circumstances, a "win" could enable physicians to apply for a refund of taxes paid prior to July 15, 1994.

Despite the obstacles, the tax is discriminatory and inherently unfair and will continue to have a chilling effect upon physician recruitment in Kentucky. In addition, historically, once a tax is levied on a segment of a population, product, or service, it becomes an easier task to raise the tax.

For these and other reasons, it seems indicated that we pursue this goal even though it appears very difficult to obtain. Many other assaults are also being made on our profession and there will be other issues requiring us to seek our day in court on behalf of Kentucky physicians. We will need and use Legal Trust Funds for substantial issues as they present themselves. Court tests are terribly expensive, so it is crucial that every physician pays his/her Legal Trust Fund dues even though the Trust Fund is considered voluntary. We thank members of KMA who have been helpful throughout this process. Our commitment to valued principles is unwavering and we stand ready to continue our fight for the profession and our patients. While we shall continue to challenge the constitutionality of certain segments of health care reform, our best hope of overturning the provider tax is in the 1996 Regular Session of the Kentucky General Assembly.

Concluding Remarks

There is no doubt this year has been the most challenging year in KMA's history. There are many changes taking place in medicine. Leadership is trying to keep physicians informed to maintain the tradition of professionalism, quality health care, and physician-patient choice and relationships. With unity of purpose, we can continue to provide the best health care system in the world. If we allow others to fragment that unity in any way, our ability to stay the course is gone.

Serving as your Chair has been a very special experience for me. I've learned you have to sit in this seat to get the true panoramic picture of what is going on within the Association, to see the many and complex attempts of outsiders to change and even take over medicine, and certainly to appreciate the efforts of the Board, officers, committees, members, and staff who do so much on behalf of Kentucky physicians. Thank you for the privilege of serving as your Board Chair.

A report on the Legal Trust Fund is included annually in the Chair's Report, and because of the ongoing provider tax lawsuit, we did have a significant expense. Following last year's expenses of $30,751.01, primarily because of the lawsuit, we had additional expenses this year of $87,586.69 as we continued the provider tax lawsuit. Our income this year was $33,370.00. The Fund's balance as we prepared this was $162,063.16.

The following summary of Board meetings is designed to give you a quick review of your Board's activities this year. Routinely our Board meetings begin on Wednesdays and are completed at noon on Thursdays. Complete minutes of all Board meetings will be provided to Reference Committee No. 1. The reports of your committee are also an excellent way to have additional insight into your Association's involvement on your behalf.

Communicate with your KMA. Learn about your KMA. Support your KMA. Our only product is providing services to you and for you.

Summary of Board Meetings

First Meeting, September 30, 1993

The KMA Board of Trustees held its reorganizational meeting for the 1993-94 Association year on September 30, 1993. Acting as temporary Chair, KMA Secretary-Treasurer William P. VonderHaar, MD, introduced the newly elected members of the Board and the new officers: Robert R. Goodin, MD, Louisville, President-Elect; William H. Mitchell, MD, Richmond, Vice President; Timothy K. Hulsey, MD, Bowling Green, Trustee, 6th District; and G. Irene Minor, MD, Berea, Trustee, 11th District. The Board elected the Executive Committee members to serve with the President, President-Elect,

Vice President, and Secretary-Treasurer for the 1993-94 KMA year. Don R. Stephens, MD, was elected Chair, Board of Trustees, and John W. McClellan, MD, Henderson, was reelected Vice Chair. Harry W. Carloss, MD, Paducah, and Russell L. Travis, MD, Lexington, were named as Trustees-at-Large.

It was noted that the KMA Executive Committee members also serve as the Boards of Directors of KMA Physicians Services, Inc (KMA's holding company), and the KMA Building Corporation.

The Board also made changes to the Kentucky Foundation for Medical Care Board of Directors in accordance with KFMC's Bylaws, and appointed KMA committees for the following year.

Second Meeting, December 15-16, 1993

Convening in a regular session, the KMA Board of Trustees met on December 15-16, 1993. The Board members heard reports of the President; Secretary-Treasurer; Senior Delegate to AMA; Alliance President; President, Board of Medical Licensure; Dean, University of Louisville School of Medicine; Chair, KEMPAC Board of Directors; Chair, KMIC Board of Directors; and Commissioner for Health Services.

Detailed reports were given on the activities of the Committees on National and State Legislative Activities. The Board heard reports of the Chairs of the newly appointed Public Education Committee and the Physician Organization Study Committee, and adopted mission statements for both groups.

The Board members endorsed a "Nonhospital DNR Legislative Proposal" as outlined for introduction into the 1994 Kentucky General Assembly, and approved changes the Board of Medical Licensure was proposing to the Medical Practice Act. Approval was also given to proposed changes to the Hospital Medical Staff Section Bylaws, and action taken by the Executive Committee to implement directives of the 1993 House of Delegates was endorsed.

It was also agreed to allow the Kentucky Foundation for Medical Care to accept contributions for use by the Impaired Physicians Committee until tax-exempt status for a separate foundation is granted by the IRS.

Appointments were made to the KMIC Board Election Nominating Committee, and selections were made for submission to the Governor for appointment to several boards and councils.

Legal Counsel provided an update on the status of KMA's lawsuit on the provider tax. A lengthy report was presented and discussion held concerning the AMA Nathan Davis Award, following which the Board voted to put this matter behind it and to direct the Association's full energies to the real crisis at hand — state and national health care reform.

Representatives of Kentucky Blue Cross and Blue Shield made a presentation regarding the KMA-endorsed BCBS plan for the membership.

Third Meeting, March 3, 1994

The Board of Trustees met in special joint session on March 3, 1994, with the Physician Organization Study Committee. The purpose of the meeting was to discuss possible interest in the managed care arena in follow up to Resolution B, adopted by the 1993 House of Delegates. The Board of Trustees subsequently decided that the Committee should act as a clearinghouse for information, conduct seminars, etc, but that KMA should not establish its own economic entity.

Fourth Meeting, April 13-14, 1994

The KMA Board of Trustees held its two-day spring meeting on April 13-14, 1994, at the Holiday Inn Hurstbourne in Louisville. The Board members heard reports from the President; Secretary-Treasurer; Alliance President; Chair, KMIC Board of Directors; Director, Medicare Part B Program; and Commissioner, Bureau for Health Services. Representatives of the Board of Medical Licensure and University of Louisville School of Medicine also made reports.

Comprehensive reports were given concerning the activities of the Committees on National and State Legislative Activities. The Board spent considerable time discussing results of the 1994 Kentucky General Assembly, with emphasis on health care reform. The Board members endorsed the action of the Executive Committee to petition for a rehearing on KMA's lawsuit challenging the constitutionality of the recently imposed provider tax, and authorized use of the Legal Trust Fund for expenses attendant to the suit.

Endorsement was given to the Committee on Public Education's plans to publish a quarterly patient newsletter, develop a speaker's bureau and slide program, and increase media communication. The recommendation of the Physician Organization Study Committee was also accepted that KMA provide information to members on managed care, through the resources of existing staff personnel and legal counsel.

Reports of the Membership Committee and the Ad Hoc Committee on the KMA/KMIC Headquarters Location were also accepted, and the Board approved plans of the Subcommittee on Domestic Violence to develop a seminar on domestic abuse. The Board members officially endorsed the concept of a Kentucky Center for Health Education and accepted the Executive Committee's report to implement a revised format for the 1996 Annual Meeting on a trial basis.

The Board adopted a budget for the 1994-95 Association year; appointed William H. Mitchell, MD, Richmond, as PRO Advisory Committee Chair; and selected Salem M. George, MD, Lebanon, to replace Nelson B. Rue, MD, on the Kentucky Health Care Access Foundation Board of Directors. Names were finalized for appointment to the KMIC Board of Directors, and nominees were selected for service on Governor-appointed councils and boards.

Fifth Meeting, August 10-11, 1994

The KMA Board of Trustees held its fifth meeting of the Association year on August 10-11, 1994, at the Holiday Inn Hurstbourne in Louisville. Reports were given by the President; Secretary-Treasurer; President, KMA Alliance; Senior Delegate to AMA; Vice Chairman, Kentucky Medical Insurance Company; and the Commissioner for Health Services. In addition, the Board heard presentations from the Dean of the University of Louisville School of Medicine and from a representative of the Board of Medical Licensure.

The Secretary of the Cabinet for Human Resources, Masten Childers, addressed the Board and announced his intention to foster improved communications with Kentucky physicians. The Board authorized the Executive Committee to form a committee to meet with the Cabinet to address matters affecting the profession.

An update was given on the status of health care reform following adoption of HB 250 by the 1994 session of the Kentucky General Assembly. The Board reaffirmed its support of the use of the Legal Trust Fund to continue its challenge to the constitutionality of HB 1, the provider tax, to fund Medicaid.

In other action, the Board approved a Resolution to be introduced into the 1994 House of Delegates to raise the $10 voluntary assessment for the Legal Trust Fund to $25, effective with the 1995 dues billing; selected physicians to serve on Governor-appointed councils; and reappointed the KEMPAC Board of Directors.

The Board reviewed its ad hoc committee reports, as well as each final committee report to be submitted to the 1994 House of Delegates. Several Board members who chair committees gave auxiliary reports, including the Chairs of the Committees on National and State Legislative Activities, Public Education, Medical Insurance and Prepayment Plans, and the Physician Organization Study Committee.

A listing of actions taken to implement the directives of the 1993 House of Delegates was distributed, and it was noted that the same information would be sent to every Delegate as an addendum to the 1994 Board Chair's Report.

The next meeting of the Board was scheduled for Sunday, September 18, 1994, during the Annual Meeting.

Executive Committee

The KMA Executive Committee meets between sessions of the full Board to guide the day-to-day operations of the Association and to give extensive consideration to major subjects presented to the Board of Trustees. The Executive Committee is composed of eight officers and Trustees, and during this past year, met on eight occasions with legislation, health system reform, and the provider tax and legal challenge thereto dominating the agenda. The number of hours worked and miles traveled by these physicians is an indication of their dedication to our members and our profession.

Quick Action Committee

Four of the Executive Committee members above serve as the Quick Action Committee: the President, President-Elect, Chair of the Board, and Secretary-Treasurer. In addition, during legislative sessions, the Chair of our State Legislative Activities Committee also serves as Chair of this group, and the immediate past president and immediate past chair of the Board were

members so their counsel would be available. At no time in history has the Quick Action Committee met so frequently, and for so long in each session. We must have had more than two dozen sessions to consider chronic and acute situations. Frankfort was our second home with members traveling weekly from the far ends of the state. Total commitment does not come packaged any better than as this group. I thanked them many times this year. I hope you do, too.

Ad Hoc Committees

This year, there were three ad hoc committees continuing to work on specific projects.

The Ad Hoc KMA/KMIC Board Liaison Committee, chaired by KMA President Ardis Hoven, MD, was appointed to ensure our two organizations' boards and staffs are fully aware of each other's goals and utilize a cooperative spirit in helping fulfill the mission of each. The Committee held one meeting this year to consider a joint meeting of the two Boards. However, because of the time pressures of the 1994 Kentucky General Assembly and the 1994 Special Session, a joint meeting was not feasible. Senior staff of both organizations do hold periodic meetings to discuss common interests.

The Ad Hoc Committee on KMA/KMIC Headquarters Location, chaired by Past President William Monnig, MD, reported that due to problems in contract negotiations and other reasons, a site for a KMA/KMIC headquarters was not finalized this year. The Committee will continue to explore options for a headquarters site and will keep the Board informed of its progress.

The Ad Hoc Committee to Implement Resolution M (1991) completed its work with the passage of Senate Bill 311 by the 1994 Kentucky General Assembly, and its report is contained in this Reports Book.

Closing Thoughts

What a year it has been. My thanks again to the House of Delegates, the Board of Trustees, the committees, and the individual members who stood tall and spoke loudly this year.

Our staff, with many years of experience and with an abundance of dedication, effort, and stamina, has carried a burdensome load. Thank you, staff. Hopefully, next year we will all continue our proper role with our Association. If we do, KMA will aspire to new heights.

Donald R. Stephens, MD
Chair

Recommendations, Reference Committee 1:

Reference Committee No. 1 reviewed the Report of the Chair, Board of Trustees, except for the Report of the Ad Hoc Committee to Implement Resolution M (1991). The Committee would like to thank Board Chair Don Stephens, MD, for his outstanding report which was well organized and summarized the meetings of the Board and its Committees.

Reference Committee No. 1 recommends that the Report of the Chair, Board of Trustees (except the Report of the Ad Hoc Committee to Implement Resolution M [1991]) be filed.

Report of the Kentucky Physicians Care Operating Committee

The KMA House of Delegates voted to approve Kentucky Physicians Care in September 1984 with an implementation date of January 1, 1985. The program was to be for one year with any extensions approved by the House of Delegates. The House has voted to extend the program nine times.

The document, "Health Care Access Committee, Tentative Report," which developed 24 recommendations on health care access, one of which led to the development of Kentucky Physicians Care by the Kentucky Medical Association, stated:

> We believe many patients don't know how to obtain access to the health care system and that a mechanism is needed to respond to questions and provide advice on health care access . . . We also believe many physicians want to serve those needing care, but want a system to facilitate the referral of such patients.

KMA has accomplished this goal, probably to a far greater extent than anyone would have dreamed possible ten years ago. The program works. It has been and continues to be a model across the United States.

Since the program began operation in January 1985, 135,368 calls have been made to the 800 number by clients asking for referrals or for information on applying for the program. In 1985, 2,124 physicians, of which 874 were primary care physicians, participated in the program. In 1994, those numbers were 2,563 and 1,073 respectively. Physician participation rose to an all time high in 1994, but has been a constant 2,300 to 2,400 throughout the program's existence.

Since 1984, 58,331 referrals have been made through the referral system. Once patients are in the system, they usually don't call back for follow-up visit authorizations. The physician usually sees them in follow up as a normal course. Similarly, referrals to nonprimary care physicians take place without going through the 800 number. The services of hospital-based specialists are not reflected in the referral numbers either, since most of these services are coordinated through the attending physician once the patient is hospitalized. Thus, it is reasonable to assume that the number of patient/physician encounters as a result of KPC is far greater than the 58,000+ logged referrals. The Committee believes an estimated ratio of four encounters per referral may be low, but even so, that would equate to over 233,000 free encounters for the 129,021 individuals who were certified for the program over its ten-year existence.

In addition to KMA's participation and that of the 100 participating Kentucky hospitals, 353 participating dentists have had 2,790 referrals since 1991. A total of 26,016 free prescriptions have been filled by 431 participating pharmacists since 1990. An unknown number of free home health care and hospice services have been provided as well. Clearly, the project has been a meaningful undertaking, and all involved can be proud of their roles.

* * * * *

In the past year, the following changes occurred within the Kentucky Health Care Access Foundation:

- Governor Jones stepped down as President of the Foundation and is no longer a member of the Board. Dr Nelson Rue succeeded Governor Jones as Foundation President but resigned due to other commitments.
- The Foundation's Executive Vice President and primary staff person to the Foundation since its inception, resigned to take a position with another organization. The Health Care Access Foundation staffing is now being carried out by an individual working on a management contract who has staff responsibilities with other organizations in addition to the Foundation. His contract is through September 1994, with month-to-month extensions after that date. The Foundation has appointed an Executive Search Committee to retain full-time staff. It has been reported that the Foundation has reaffirmed its mission and plans to expand its funding sources.
- The Foundation, citing financial pressure and a need to add more staff to the referral office last fall, recommended that the referral staff become state employees. KMA was told that while there could be no guarantee the staff would remain headquartered in Louisville, where most of the participating organizations are headquartered, every effort would be made to keep the referral office as it was before the change in employment. The change was agreed to by each of the associations participating in the Foundation programs. Late in 1993, the referral staff was relocated from KMA/KMIC headquarters to a state office building in Louisville. The referral function then moved from Louisville to Frankfort and is housed somewhere in the Cabinet for Human Resources bureaucracy as of June 30, 1994. Referral staff was asked to relocate to Frankfort but was unable to make that change.
- Resolution A, passed by the House in 1984 to implement KPC, stated, "The operation of the hot line referral system will be under the complete control of the KMA . . . " When the hot line staff, one of whom had been with the program since its inception and the other who had been with the program eight years, transferred their employment from the Foundation to the state, KMA still had significant input because of that long-term relationship. However, neither employee was able to commute to Frankfort when the office was moved.

In light of these events, the Operating Committee discussed what the future role of KMA should be. One option would be to monitor the program

as the state takes on a larger responsibility in the program and take appropriate action as necessary. It is possible the changes in the Foundation and referral staff could take place with no noticeable effect on the program. However, we believe this does not meet the House of Delegates requirement of total control of the program.

The second alternative might be to discontinue the program. Political, economic, and demographic changes have occurred over the years which have affected Kentucky physicians. The program was developed to serve as a laboratory to study demographics of the uninsured and a temporary attempt to help the less fortunate among us until society assumed its rightful obligation for that group of people. However, there will probably always be a need for a safety net like KPC and it would not be appropriate to discontinue a service that has helped so many people in the past.

The Committee believes the most reasonable action is to transfer control and responsibility for KPC to the Kentucky Health Care Access Foundation. When the program began in 1985, the main participants were KMA and the Kentucky Hospital Association. Since then, the program has grown to include pharmacies, pharmaceutical manufacturers, home health care, dentistry, hospice, visiting nurses, and others. Because of this growth, it is appropriate for the entire project to be coordinated directly through the auspices of the Foundation. KMA is represented by three physicians serving on the Foundation Board that also serve on the KMA Board of Trustees, so organizational continuity would be maintained and physician advisors would be available. If any major policy decisions came up that needed a KMA response, they could be brought back to KMA for resolution.

KMA's ongoing role in the KPC program has been concept endorsement and solicitation of participating physicians, as well as providing staff advisors, equipment, supplies, office space, postage, and computer programming and equipment. KMA has also provided support for Foundation fundraising activities. KMA's current role has largely become one of program endorsement. The KPC Operating Committee meets infrequently. KMA staff no longer provides direct supervision of the referral staff, and KMA no longer provides space, equipment, and supplies. The transfer of the program responsibility to the Foundation would simply formalize what is now being done in practice.

When the KPC program began, the Foundation did not exist. By the time the Foundation was established, the referral program was in place and operational. The consensus at the time was to operate KPC as a separate component under the coordination of the Kentucky Health Care Access Foundation. The overall project has expanded with many entities now involved, and KMA is pleased to have been a major participant and catalyst for the program. However, it now seems more appropriate for the overall project to be more centrally coordinated and the Committee recommends:

1. Overall responsibility for the continued operation and coordination of the Kentucky Physicians Care program be transferred to the Kentucky Health Care Access Foundation by January 1, 1995.
2. KMA continue to appoint the three physician KMA members of the Kentucky Health Care Access Foundation Board of Directors.
3. KMA continue its endorsement of the Kentucky Health Care Access Foundation goal of increasing access to care for Kentucky's less fortunate citizens.
4. KMA encourage all Kentucky physicians to continue to voluntarily participate in Kentucky Physicians Care to the extent possible.
5. KMA continue its endorsement of the Kentucky Health Care Access Foundation contingent on:
   a. Program funding being continued, as appropriate, by the Kentucky Health Care Access Foundation.
   b. A continuing commitment from the Cabinet for Human Resources to evaluate program applicants for eligibility as is currently done.
   c. The other participating provider groups maintaining same or increased level of participation in the Foundation program.
   d. The Kentucky Health Care Access Foundation making documented efforts to vigorously encourage the active participation of all other health care delivery and/or financing organizations in the Foundation's programs as may be appropriate.
   e. The Kentucky Health Care Access Foundation making documented efforts to make Kentucky legislators and the general public aware of the plight of those ineligible for Medicaid assistance solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

Russell L. Travis, MD
Chair

RECOMMENDATIONS:

1. Overall responsibility for the continued operation and coordination of the Kentucky Physicians Care program be transferred to the Kentucky Health Care Access Foundation by January 1, 1995.
2. KMA continue to appoint the three physician KMA members of the Kentucky Health Care Access Foundation Board of Directors.
3. KMA continue its endorsement of the Kentucky Health Care Access Foundation goal of increasing access to care for Kentucky's less fortunate citizens.
4. KMA encourage all Kentucky physicians to continue to voluntarily participate in Kentucky Physicians Care to the extent possible.
5. KMA continue its endorsement of the Kentucky Health Care Access Foundation contingent on:
   a. Program funding being continued, as appropriate, by the Kentucky Health Care Access Foundation.
   b. A continuing commitment from the Cabinet for Human Resources to evaluate program applicants for eligibility as is currently done.
   c. The other participating provider groups maintaining same or increased level of participation in the Foundation program.
   d. The Kentucky Health Care Access Foundation making documented efforts to vigorously encourage the active participation of all other health care delivery and/or financing organizations in the Foundation's programs as may be appropriate.
   e. The Kentucky Health Care Access Foundation making documented efforts to make Kentucky legislators and the general public aware of the plight of those ineligible for Medicaid assistance solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

Recommendations, Reference Committee 1:

Reference Committee No. 1 heard discussion on the Report of the Kentucky Physicians Care Operating Committee and thanks Russell Travis, MD, for his report and historical perspective, noting in particular the fact that the operations of the KPC Program have now been moved to the Department for Human Resources in Frankfort, after having been housed at no charge by the KMA and KMIC for a number of years.

Since KMA's ability to monitor the Program is now limited, the Committee recommends the adoption of the Report of the Kentucky Physicians Care Operating Committee and its recommendations.

RESOLUTION D

KMA Legal Trust Fund
KMA Board of Trustees

WHEREAS, Resolution Q (1973) established the Legal Trust Fund; and

WHEREAS, Resolution C (1978) and Resolution A (1986) amended Resolution Q (1973) and Legal Trust Fund Guidelines to allow for an annual voluntary assessment of the entire KMA active membership in an amount not to exceed $10.00 per year to provide financial support to the Fund; and

WHEREAS, the current legal challenge to the constitutionality of the House Bill 1 provider tax, which seeks to defend and uphold the rights of all Kentucky physicians, and other potential legal challenges to certain health system reform legislative measures, are reducing the Fund in amounts that the current annual voluntary $10.00 assessment does not sufficiently replenish; now, therefore, be it

RESOLVED, that KMA policy and Legal Trust Fund Guidelines be amended to allow the annual voluntary assessment of the entire KMA active membership in an amount to be determined by the Fund trustee (KMA Board of Trustees), said amount not to exceed $25.00 per year; and further, that the voluntary assessment be set at $25.00, effective for the 1994-95 Association year and its corresponding dues billing cycle; and be it further

RESOLVED, that the House of Delegates strongly urges all KMA members to voluntarily contribute to the Legal Trust Fund.

Recommendations, Reference Committee 1:
The Committee next reviewed Resolution D, KMA Legal Trust Fund, submitted by the Board of Trustees.

Reference Committee No. 1 recommends Resolution D be adopted.

RESOLUTION I

Provider Tax Protest
Jefferson County Medical Society

WHEREAS, the Kentucky General Assembly imposed the provider tax in 1994, ignoring the objections of physicians, the inherent unfairness, and potential unconstitutionality of the tax; and

WHEREAS, Kentucky's General Fund has derived surpluses directly resulting from the provider tax; and

WHEREAS, the Cabinet for Human Resources has openly proposed cutting physician reimbursement in the Medicaid program; now, therefore, be it

RESOLVED, if Kentucky reduces physician reimbursement in the Medicaid program the KMA should immediately investigate legally viable options for physicians to reconsider their participation in Medicaid.

RESOLUTION P

Expanded Indigent Care by Kentucky Physicians
Fayette County Medical Society

WHEREAS, the current Kentucky state governmental administration appears to be continuing its onslaught of onerous and adverse governmental activity against Kentucky physicians by imposing:

1. an unconstitutional provider tax,
2. illegal rate fixation through the Discount Option Program (DOP),
3. the potential for excessive government control of medicine through the five-person Kentucky Health Policy Board,
4. unilateral aggressive pursuit of a managed care system in Kentucky without any meaningful provider input, and
5. continued severe reductions in already inadequate Medicaid reimbursement schedules; and

WHEREAS, Kentucky physicians have not received grass-roots support due them from Kentucky constituencies of the legislators responsible for the above adverse activities, in spite of intensive lobbying efforts during the last legislative session; and

WHEREAS, Governor Jones has shown callous disregard and lack of appreciation for the efforts of those physicians giving FREE medical care to the indigent through his Kentucky Physicians Care Program, which was a major factor in the success of his election campaign; and

WHEREAS, the Jones' administration has unjustly excluded meaningful physician input in its efforts at health care reform, which most Kentucky physicians support; and

WHEREAS, the above activities are creating a hostile environment for physicians in Kentucky, already discouraging qualified and desirable physicians from practicing in Kentucky, thereby reducing quality of care as well as access; and

WHEREAS, only so much adverse governmental activity can be tolerated by Kentucky physicians; and

WHEREAS, Kentucky physicians support the concept of universal coverage and in many cases give FREE care to the truly indigent; now, therefore, be it

RESOLVED, that in an effort to gain grass-roots constituency support and to demonstrate the good faith of Kentucky physicians toward achieving the goal of universal coverage and health care reform, the Kentucky Medical Association support an expansion of the Kentucky Physicians Care Program in which physicians, on a voluntary basis, give FREE care to the truly indigent (defined by a state agency with physician input) contingent on tangible efforts by the current state administration (as determined by the KMA Board of Trustees) to improve the hostile medical environment in Kentucky.

RESOLUTION U

Medicaid
KMA Board of Trustees

WHEREAS, the 1994 Kentucky General Assembly, with the recommendation of Governor Brereton C. Jones, levied a two percent (2%) tax on physicians' gross patient revenues; and

WHEREAS, following the Special Session in May 1993 on Health System Reform and the regular 1994 session of the General Assembly, the needs of the uninsured remain unfulfilled; and

WHEREAS, 2,500 Kentucky physicians participate in the Kentucky Physicians Care Program which has provided over one-quarter of a million physician-patient encounters free of charge; and

WHEREAS, Governor Jones has announced a $50 million reimbursement reduction in physician reimbursement and ordered other reimbursement administrative strategies to further reduce payment for Medicaid patients; and

WHEREAS, the Governor has proclaimed a $100 to $143 million surplus in state government for the fiscal year of which $128 million is the result of the provider tax; now, therefore, be it

RESOLVED, that the KMA enlist the support of members of the Kentucky General Assembly to oppose Governor Jones' and the Cabinet for Human Resources' proposal to unilaterally reduce reimbursement; and be it further

RESOLVED, that KMA contact the Kentucky Congressional Delegation and explain the potential ramifications reimbursement cuts will have on access to care for the poor and Medicaid recipients; and be it further

RESOLVED, that KMA explore legal ramifications of drastic reductions in Medicaid reimbursement, particularly as it relates to the Boren Amendment; and be it further

RESOLVED, that HCFA and other federal agencies, along with patient advocacy organizations including representatives of elderly groups, be made aware of the problem; and be it further

RESOLVED, that KMA continue to support the Kentucky Physicians Care Program and urge its members to render necessary medical care to the poor and indigent regardless of ability to pay; and be it further

RESOLVED, that if corrective action is not achieved, KMA can no longer urge its members to support a Medicaid program that is not in the best interest of patient access to care; and be it further

RESOLVED, that a copy of this Resolution, with appropriate background information and data, be forwarded to every television and radio station and newspaper in Kentucky.

Recommendations, Reference Committee 1:
Reference Committee No. 1 next heard much discussion on Resolution I, Provider Tax Protest, submitted by the Jefferson County Medical Society; Resolution P, Expanded Indigent Care by Kentucky Physicians, introduced by the Fayette County Medical Society; and Resolution U, Medicaid, submitted by the Board of Trustees.

The Reference Committee recommends that Resolution U be amended by insertion of a new fifth "Whereas" and by moving the existing fifth "Resolved" to become the first "Resolved" so that Resolution U now reads as follows:

WHEREAS, the 1994 Kentucky General Assembly, with the recommendation of Governor Brereton C. Jones, levied a two percent (2%) tax on physicians' gross patient revenues; and

WHEREAS, following the Special Session in May 1993 on Health System Reform and the regular 1994 session of the General Assembly, the needs of the uninsured remain unfulfilled, and

WHEREAS, 2,500 Kentucky physicians participate in the Kentucky Physicians Care Program which has provided one-quarter of a million physician-patient encounters free of charge; and

WHEREAS, Governor Jones has announced a $50 million reimbursement reduction in physician reimbursement and ordered other reimbursement administrative strategies to further reduce payment for Medicaid patients; and

<u>WHEREAS, a reduction in Medicaid reimbursement will significantly impact and diminish the access, delivery, and quality of medical care to the poor, and can impact the quality of medical education, and</u>

WHEREAS, the Governor has proclaimed a $100 to $143 million surplus

in state government for the fiscal year of which $128 million is the result of the provider tax; now, therefore, be it

RESOLVED, that KMA continue to support the Kentucky Physicians Care Program and urge its members to render necessary medical care to the poor and indigent regardless of ability to pay; and be it further

RESOLVED, that the KMA enlist the support of members of the Kentucky General Assembly to oppose Governor Jones' and the Cabinet for Human Resources' proposal to unilaterally reduce reimbursement; and be it further

RESOLVED, that KMA contact the Kentucky Congressional Delegation and explain the potential ramifications reimbursement cuts will have on access to care for the poor and Medicaid recipients; and be it further

RESOLVED, that KMA explore legal ramifications of drastic reductions in Medicaid reimbursement, particularly as it relates to the Boren Amendment, which specifically states that it is illegal to adversely impact access to medical care in a geographic region; and be it further

RESOLVED, that HCFA and other federal agencies, along with patient advocacy organizations including representatives of senior groups, be made aware of the problem; and be it further

RESOLVED, that if corrective action is not achieved, KMA can no longer urge its members to support a Medicaid program that is not in the best interest of patient access to care; and be it further

RESOLVED, that a copy of this Resolution, with appropriate background and data, be forwarded to every television and radio station and newspaper in Kentucky.

Reference Committee No. 1 recommends that Resolution U, as amended, be adopted in lieu of Resolutions I and P.

RESOLUTION J

Provider Tax Credits
Jefferson County Medical Society

WHEREAS, the Kentucky Physicians Care program was formed as a safety net to offer access to medical care for Kentucky's less fortunate citizens who do not qualify for Medicaid; and

WHEREAS, the KMA's Kentucky Physicians Care Operating Committee has recommended continued endorsement, contingent upon the Kentucky Health Care Access Foundation making documented efforts to make Kentucky legislators and the general public aware of the plight of those ineligible for Medicaid assistance solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance; and

WHEREAS, participating physicians in the Kentucky Physicians Care program rose to an all-time high in 1994, with a total of 2,563 physicians providing free care, 1,073 of whom were primary care physicians; and

WHEREAS, in the ten years of the program's existence it is conservatively estimated that volunteer physicians have contributed more than 233,000 free encounters for the 129,000 individuals certified as eligible for Kentucky Physicians Care; and

WHEREAS, the Kentucky General Assembly has imposed a 2% tax on gross incomes of physicians for the purpose of funding the Medicaid program; and

WHEREAS, the state has experienced budget surpluses for the past two years, due in a large part to the provider tax revenues; and

WHEREAS, the Cabinet for Human Resources recently has imposed a $50 million reduction in Medicaid reimbursement levels to physicians; now, therefore, be it

RESOLVED, that the Kentucky Medical Association House of Delegates endorse the concept of the enactment of a provider tax credit for free services provided through the Kentucky Physicians Care program; and be it further

RESOLVED, that the KMA Legislative Quick Action Committee and staff work with legislators for the introduction and passage of legislation providing that Kentucky Physicians Care program participating physicians' provider tax liability be reduced by the dollar value of unreimbursed services provided to Kentucky Physicians Care certified patients.

Recommendations, Reference Committee 1:
Reference Committee No. 1 next considered Resolution J, Provider Tax Credits, submitted by the Jefferson County Medical Society, and heard testimony that adoption of the Resolution might imply that KMA supported the constitutionality of the provider tax.

After thorough discussion, the Committee recommends that Resolution J be rejected.

RESOLUTION Q

Inclusion of Sleep Medicine in AMA Codes for Self-Designation
Fayette County Medical Society

WHEREAS, sleep disorders greatly impact mortality, morbidity, and quality of life; and

WHEREAS, the field of knowledge in Sleep Disordered Medicine has tremendously increased since its inception in 1975, with a standard text, *Principles and Practice of Sleep Medicine*, and with several referenced journals in sleep worldwide, including *SLEEP, (EUROPEAN) JOURNAL OF SLEEP RESEARCH,* and others; and

WHEREAS, in 1993 the National Institutes of Health established the National Center for Sleep Disorders Research in order to specifically study sleep disorders and their treatments; and

WHEREAS, the field of Sleep Medicine impacts many other areas of medicine; and

WHEREAS, there is an independent national examination board, in existence since 1978, that administers the board examination certifying physicians in Sleep Medicine; and

WHEREAS, there are now over 600 physicians who are certified in Sleep Medicine by the American Board of Sleep Medicine; and

WHEREAS, there are 26 fellowship training programs in Sleep Medicine, of which 12 are currently certified by the American Sleep Disorders Association as comprehensive training programs in Sleep Medicine, and candidates for these programs must have completed an ACGME-accredited residency program in family practice, general surgery, internal medicine, neurology, otolaryngology, pediatrics, or psychiatry; and

WHEREAS, the American Sleep Disorders Association and the American Board of Sleep Medicine are actively engaged in discussion with the American Board of Medical Specialties to eventually move the examination process of the American Board of Sleep Medicine under governance of the American Board of Medical Specialties; and

WHEREAS, there is a tremendous need to provide quality diagnosis and treatment services to the population of those suffering with sleep disorders; now, therefore, be it

RESOLVED, that the KMA urge consideration of the inclusion of Sleep Medicine in AMA Codes for Self-Designation by the appropriate committee of the American Medical Association.

Recommendations, Reference Committee 1:
Reference Committee No. 1 reviewed Resolution Q, Inclusion of Sleep Medicine in AMA Codes for Self-Designation, as introduced by the Fayette County Medical Society. Expert testimony was heard in this discussion.

Reference Committee No. 1 recommends that Resolution Q be adopted.

Mr Speaker, Reference Committee No. 1 recommends the adoption of this report as a whole.

Mr Speaker, I want to thank the members of Reference Committee No. 1 who worked hard to assist the House of Delegates on these matters. Other members of the Committee were: Susan M. Berberich, MD, Louisville; James M. Bowles, MD, Madisonville; Peter E. Locken, MD, Paducah; Mohan K. Rao, MD, Madisonville; and W. Ford Threlkeld, Frankfort. I also wish to thank Diane Maxey for her help and guidance in preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE NO. 1
John W. Collins, MD, Lexington, Chair
Susan M. Berberich, MD, Louisville
James M. Bowles, MD, Madisonville
Peter E. Locken, MD, Paducah
Mohan K. Rao, MD, Madisonville
W. Ford Threlkeld, MD, Frankfort

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 2

Thomas K. Slabaugh, MD, Lexington, Chair

15. Report of the Scientific Program Committee
16. Report of the Scientific Exhibits Committee
17. Report of the Continuing Medical Education Committee
18. Report of the Council on Continuing Medical Education
19. Report of the Cancer Committee
20. Report of the Physician Manpower Committee
21. Report of the Hospital Medical Staff Section
22. Report of the Rural Kentucky Medical Scholarship Fund

Resolution B — Economic Credentialing
(Northern Kentucky Medical Society)
Resolution K — Smoke-Free Dining
(Jefferson County Medical Society)
Resolution O — CME for Retired Physicians
(Bowling Green-Warren County Medical Society)
Resolution W — Character Assassination
(KMA Board of Trustees)

ITEMS FOR CONSENT

Reference Committee No. 2 reviewed the following items and recommends they be filed, by consent of the House, without discussion:

15. Report of the Scientific Program Committee — filed
16. Report of the Scientific Exhibits Committee — filed
18. Report of the Council on Continuing Medical Education — filed
19. Report of the Cancer Committee — filed
21. Report of the Hospital Medical Staff Section — filed
22. Report of the Rural Kentucky Medical Scholarship Fund — filed

Mr Speaker, Reference Committee No. 2 recommends adoption of the Consent Calendar as a whole.

Report of the Scientific Program Committee

"The Art of Medicine" was selected by the Scientific Program Committee as the overall theme for the 1994 KMA Annual Meeting Scientific Program. Each morning session will focus on the theme from the perspective of the various specialties participating in the meeting. The Committee members and representatives of the planning committee from the 23 specialty societies have worked hard to bring some of this country's outstanding speakers to the meeting, and it is hoped that the membership will find their presentations useful.

The Scientific Program was planned last fall and a meeting was held in December with the presidents and/or representatives of the 23 specialty groups that will participate in the annual session. Specialty groups' scientific programs held in conjunction with the morning general sessions have proven invaluable, and provide an excellent contribution to the continuing medical education of the membership. I personally appreciate the excellent cooperation the Committee has had from the specialty societies in planning the overall meeting, and I thank them for their suggestions and assistance.

The 1993 Annual Meeting was held at the Hyatt Regency Hotel/Commonwealth Convention Center, with an attendance of 2,630.

Exhibitors were asked to fill out evaluation forms on Tuesday, Wednesday, and Thursday during the 1993 meeting. This allowed a better assessment of exhibitors' viewpoints which were, overall, positive.

Results from physicians' evaluation forms were very positive and revealed that physicians attended the 1993 Annual Meeting program because of the program content.

The Kentucky Medical Insurance Company will again sponsor a Risk Management Workshop for Office Assistants, and this year will add a separate workshop for physicians. In addition to the regular general sessions program, the Committee has developed a two-hour HIV/AIDS course for physicians. Ardis D. Hoven, MD, KMA President, has been instrumental in planning a top-notch program which will be offered for two hours of AMA PRA Category 1 credit. The course has also been approved by the Cabinet for Human Resources and meets the requirements of the mandatory CME regulation for physicians.

The 1994 KMA Annual Meeting will again be held at the Hyatt Regency Hotel/Commonwealth Convention Center in Louisville. Meetings of the KMA Board of Trustees, House of Delegates, Reference Committees, KEMPAC, and Alliance, as well as various food functions, will be held in the Hyatt Regency Hotel. General registration, specialty group meetings, general sessions, and the technical exhibit hall will be located in the Commonwealth Convention Center. We urge members and their staffs to visit the exhibits. These informal contacts offer opportunities for discussion of new products and familiarization with new equipment, free from the interruptions or distractions of the office or hospital.

The format for the general sessions was changed for the 1993 Annual Meeting on a trial basis, and the revised format will be used again this year. General scientific sessions will be held on Tuesday and Wednesday mornings, and specialty groups will meet on Tuesday and Wednesday afternoons and Thursday morning. For the past several years, attendance for the Thursday morning general session has been very low with visiting guest speakers addressing five or six people. In addition, specialty groups meeting on Thursday afternoon voiced concern to the Committee that by the time their meetings were held, many of the exhibitors had dismantled their displays. In review of the format for the 1994 Annual Meeting, the Committee agreed that last year's format worked well for all involved parties and approved the change for the 1994 meeting.

The scientific sessions are again designated for AMA PRA Category 1 continuing medical education credit and are also approved for CME credit by the American Academy of Family Physicians.

I am very grateful for the efforts of all those individuals who have assisted in the formation of another outstanding program, particularly the Program Committee, specialty group presidents, and program chairs. Suggestions for future programs are always welcomed by the Scientific Program Committee.

Sonia R. Teller, MD, PhD
Chair

Report of the Scientific Exhibits Committee

Although the Scientific Exhibits Committee does not meet formally, the work that is put into the scientific exhibits area continues to strengthen and increase the overall success of the Annual Scientific Meeting. The activities of the Committee are carried out by mail and telephone. We notify members through the *Journal of the Kentucky Medical Association* and the "Communicator" of the availability of space and provide applications to interested individuals. In 1993 six outstanding scientific exhibits were approved by the Scientific Exhibits Committee. We also provide exhibit space for entities such as the Impaired Physicians Committee. We wish to express our appreciation to the following exhibitors at the 1993 Annual Meeting:

Brain Tumor in Adults: A 20-Year Experience of 1010 Operative Cases
John J. Guarnaschelli, MD; David A. Petruska, MD; and Freida Manion, RN
Surgical Treatment for Aortoiliac Occlusive Disease
Sibu P. Saha, MD; Anthony G. Rogers, MD; Gary F. Earle, MD; and A. Brian Wilcox, MD
Functional Results of Lumbar Spine Fusions
H. Brooks Morgan, MD; John J. Vaughan, MD: and Marion Bruestle, RN
The Diagnosis of Acoustic Neuromas: A Guide for the Primary Care Physician
Mr. Greg Hood; Ms. Katrina Hood; John Guarnaschelli, MD; and Gorden T. McMurry, MD
Kentucky Cancer Program
Ms. Connie Sorrell and Ms. Pam Temple
How to Formulate a Differential Diagnosis Involving TMJ Disorders
John D. Tarrant, DMD

We would also like to congratulate the exhibitors of "Brain Tumor in Adults: A 20-Year Experience of 1010 Operative Cases," the recipient of the 1993 Award of Excellence.

I want to take this opportunity to thank the members of the Committee for serving. The scientific exhibits area remains an important avenue for

the exchange of essential scientific information at the Annual Scientific Meeting, and we encourage all physicians to take time at the meeting to visit with the scientific exhibitors.

Richard A. Kielar, MD
Chair

Report of the Council on Continuing Medical Education

The Council on Continuing Medical Education met on three occasions this year, with all three meetings held jointly with the CME Committee.

Since the Council on Continuing Medical Education serves as the provider of CME for the Association, it focuses much of its efforts on the Annual Scientific Program. The Council reviewed the theme, "The Art of Medicine," and the draft of the program for the 1994 KMA Annual Meeting from the work of the Scientific Program Committee. The Council reviewed evaluation forms from the 1993 Annual Scientific Session, as well as 1994 Scientific Program speakers, topics, and objectives.

The Council is accredited by the Accreditation Council on Continuing Medical Education (ACCME) to provide continuing medical education for physicians in Kentucky. The Council submitted an interim report of its CME activities to the ACCME. The purpose of the interim report is to inform the ACCME of activities that have taken place since ACCME last reviewed the KMA in 1991. The results of the interim report showed that KMA, through the work of the Council on Continuing Medical Education, is now in substantial compliance with all the major Essentials. The Council will undergo another formal survey by the ACCME in 1995.

The Council looked at its joint sponsorship policy used for working with nonaccredited organizations who request joint sponsorship. The Council approved a change in its joint sponsorship policy, as follows:

> Joint sponsorship will be considered on an individual basis. The Council may approve or decline any request for joint sponsorship for any reason deemed appropriate. The Council on CME will encourage organizations seeking joint sponsorship to use other available mechanisms or attain independent accreditation status.

After invoking the new addition to the joint sponsorship policy, the Council agreed to joint sponsor the Jefferson County Medical Society's program on Medical Malpractice. Staff worked closely with representatives of the Jefferson County Medical Society in conducting the program. The Council's approval for joint sponsorship was on a one-time only basis, and the Council recommended that the Jefferson County Medical Society work toward a separate accreditation under the CME Committee.

The Council worked with different committees of the Association to plan and designate educational activities for AMA PRA Category 1 credit. The Hospital Medical Staff Section of the Association submitted a need to the Council to hold a seminar on new trends in managed care. After assessing an appropriate need for the seminar, the Council assisted in planning the program with representatives of the Hospital Medical Staff Section and designated the seminar for four hours of Category 1 credit.

In an effort to help the membership of the Association understand the effects of the new laws passed by the 1994 General Assembly, the Legislative Quick Action Committee approached the Council to assist in planning and implementing a series of Health System Reform Seminars in each KMA Trustee District. Due to the timely nature of the information to be presented, the seminars were planned and implemented on short notice and were designated for three hours of AMA PRA Category 2 credit.

The Council considered the need for a seminar from the Subcommittee on Domestic Violence for physicians on domestic violence awareness. The Council approved the need for the seminar and will work closely with representatives from the Subcommittee on Domestic Violence to conduct a seminar on domestic violence issues on October 22, 1994.

The Council also conducted a seminar jointly with the CME Committee which attracted 75 attendees. Attendees at the seminar heard topics on "Surveyor Training: A Mock Site Survey"; "Essential#1 — The Mission Statement"; "AMA PRA Category 1 and 2 Credit"; "Documentation of the Essentials"; "Mandatory CME for Physicians — The Kentucky Regulation"; and "The Standards for Commercial Support — Working with Industry." Breakout session topics included "Essential #7 — Joint Sponsorship"; "An Overview of the Essentials"; "Working with your CME Committee"; and "Remedial/Focused Education."

Although serving as site surveyors for organizations accredited by the KMA is not the responsibility of the Council on Continuing Medical Education, most members of the Council volunteered their time and served as site surveyors for organizations submitting applications for accreditation under the auspices of the CME Committee. Serving as a site surveyor is an effective way to stay current on the accreditation process as well as oversee the important steps of the Essentials that all organizations, including the KMA, must maintain in planning continuing medical education activities.

During the coming year, the Council will continue to judiciously address requests for joint sponsorship from nonaccredited organizations, and will work to fulfill the recommendations of the ACCME to maintain a high level of quality continuing medical education offerings in Kentucky.

The Council would like to thank the Board of Trustees for being permitted to serve, and looks forward to expanded activity in 1994-95.

James L. Borders, MD
Chair

Report of the Cancer Committee

The Cancer Committee met on one occasion this year to review and discuss current issues and concerns in the field of cancer treatment.

The Committee reviewed the appropriateness of rural family physicians performing tests and procedures usually administered by a board-certified gynecologist. Correspondence had taken place between a family practitioner and the Division of Family Planning, Department for Health Services, Cabinet for Human Resources, regarding abnormal test results. Federal guidelines require that a woman found to have an abnormal Pap smear defined as mild dysplasia (lo-grade SIL) or above, be advised of the need to see a gynecologist for further diagnosis and treatment. If the woman chooses to see her family physician she may do so and may not be mandated to do otherwise. The intent of the guidelines is to ensure that a woman in need of further diagnosis and treatment is, first of all, advised of the need and, secondly, advised that the specialist is generally the best prepared to do both.

The concern noted in correspondence from the rural practitioner was that specialists in some rural areas were not seeing new patients, so referral to specialists has been a problem for some women.

After reviewing the concerns expressed in the letter by the family practitioner, the Committee recommended that family physicians, in their everyday practice, see patients who have a broad variety of illnesses. The Committee stressed that in dealing with advanced procedures and/or abnormal test results, expertise and volume play a decisive role in diagnosis and, in most cases, specialists are specifically trained to deal with these types of cases.

The Committee also discussed the mammography practice survey sent to all radiologists in Kentucky. Committee member Gilbert Friedell, MD, conducted and tabulated the survey on behalf of the Committee. The results of the survey showed a low response rate and therefore were not statistically valid. It was noted that, in many cases, one individual completed the survey for his/her group practice or unit at a hospital facility, so it was difficult to determine how many individual representative surveys had actually been returned. After reviewing the survey, the Committee noted several reasons why the response was low, including:

— many radiologists may not keep accurate records of all screening mammography performed, as many are sent to other physicians;
— the mammography may be ordered by one physician and read by another; and
— the reporting categories differ depending on various methods employed by radiologists. Therefore, an accurate count could not be maintained based on screenings reported.

The Committee discussed the fact that the screening mammograms taken in some parts of the state were lower quality compared to others based on the equipment used. The Committee discussed the new FDA quality standards of mammography facilities which are scheduled to take effect on October 1, 1994. All mammography facilities in the United States have until October 1, 1994, to meet new federal quality standards and be certified by the United States Food and Drug Administration in order to stay in business. The standards also coordinate overlapping federal, state, private, and voluntary standards, which will simplify the process of certifica-

tion. The Committee agreed that the new standards will serve great benefit in increasing the quality of the mammograms.

The Committee recommended that to get an accurate assessment of mammography practices in Kentucky, a case study should be performed on a facility which has maintained accurate records. The Committee will discuss this issue at subsequent meetings.

Other activities of the Committee included supporting a grant application for additional funding for the Cabinet for Human Resources from the Centers for Disease Control. The new funding to the Cabinet for Human Resources would serve to expand the capacity of the breast and cervical cancer screening services program to provide needed public and professional education services, to develop needed quality assurance measures, and to improve monitoring and evaluations of the program. The Committee supports all efforts to increase detection of cancer in Kentucky.

The Committee also reviewed the work of the Kentucky Cancer Program in conducting the Breast Cancer Leadership Summit. The purpose of the Summit was to target employers in Kentucky in order to highlight worksite screening programs in the state. The Kentucky Medical Association served as a sponsor of the Summit and some representatives of the Committee worked on various planning for the Summit. The Summit was successful and attracted over 200 people to hear presentations on community resources and efforts to increase worksite breast cancer screenings.

The Committee will meet again in the fall of 1994 and would like to thank the Board for being permitted to serve.

Clinton C. Cook, III, MD
Chair

Report of the Hospital Medical Staff Section

The Hospital Medical Staff Section (HMSS), established in 1984 to provide a forum for discussion of mutual problems of hospital medical staffs, continues to see increased participation by hospital medical staff representatives in activities of the Section.

The HMSS Steering Committee works toward planning education programs each year that will include information for physicians that is vital to their individual practices and their function as members of the medical staff of their hospitals. The Committee met several times during the course of the year to plan its 1993-94 annual meeting. This annual meeting was held on November 18, 1993, at the Alliant Medical Pavilion in Louisville.

The Section was honored to have present at its annual meeting a distinguished faculty of presenters. These presenters included: Ardis Hoven, MD, KMA President; William Monnig, MD, KMA Immediate Past President; Edmund Jones, MD, AMA-HMSS Governing Council; Donald Swikert, MD, Immediate Past Chairman, KMA-HMSS; and Charles J. "Mike" Cronan, Esquire, KMA's outside legal counsel. Topics of discussion included JCAHO accreditation requirements for 1994, patient outcome data and quality assurance, legal issues concerning medical staff governance, and various managed care issues. The KMA-HMSS Steering Committee continues to meet on a regular basis to plan the 1994-95 annual meeting. Dates, location, and topics for the meeting will be released in the near future.

Several KMA members attended the AMA-HMSS meetings in December 1993 and June 1994. It is with a great deal of pride that I announce William Monnig, MD, former KMA President and Founding Chair of the KMA-HMSS, was elected by his colleagues to serve on the AMA-HMSS Governing Council. The AMA-HMSS continues to promote a program it has developed called "Medicine in Transition: Managing Change in a New Environment," which is an extensive tool designed to educate AMA members about managed care and its impact on their practices. This appears to be an excellent program with the following five components:

1. A series of books and videotapes that provides practical information about managed care, including an in-depth understanding of physicians' rights and options and how managed care works, and explains the legal implications of managed care and contract negotiations — Doctors Resources Service (DRS).
2. American Medical Television broadcasts on managed care, to include personal interviews with physicians who have excelled in the managed care environment and national managed care experts.
3. A national network of legal and business managed care experts to provide affordable "hands-on" services to AMA members as they respond to members' needs to identify physician-friendly advocates. The network will include physicians who will provide peer-to-peer consultations to allow members to avoid pitfalls that others have overcome and will stimulate creative solutions.
4. A series of managed care workshops that can be taken around the country emphasizing practical approaches to the challenges of managed care.

It should also be noted that the KMA-HMSS participated in the KMA Membership Booth during the 1993 KMA Annual Meeting. This opportunity allowed many physicians to learn of KMA-HMSS and AMA-HMSS activities.

The Steering Committee would like to thank the members of the 1993-94 HMSS Nominating Committee for their dedicated work in selecting candidates for Steering Committee positions. The members of the Nominating Committee are Kenneth E. Green, MD, Leitchfield; Robert J. Emslie, MD, Bowling Green; William D. Pratt, MD, London; H. Michael Oghia, MD, Russell Springs; and John D. O'Brien, MD, Louisville.

As Chairman of the KMA Hospital Medical Staff Section, I would like to take this opportunity to express appreciation to medical staffs and Section representatives of those hospitals who have chosen to participate in the KMA-HMSS. I am also grateful for the dedication of the members of the 1993-94 Steering Committee for their efforts to make the HMSS an effective KMA activity. Those members are Kenneth E. Green, MD, Leitchfield, Vice Chair; Rex Cox, MD, Louisville, Secretary; William D. Pratt, MD, London, Delegate; H. Michael Oghia, MD, Russell Springs, Alternate Delegate; and Robert Emslie, MD, Bowling Green, and William Albert, MD, Russellville, Members at Large.

The HMSS will continue working toward its goal of having active participation from the medical staff of each eligible hospital in Kentucky and providing whatever assistance it can to medical staff members. This is a positive step toward assuring good working relationships between physicians and hospitals, and I urge each physician to see that the medical staff of his or her hospital becomes actively involved in the KMA and AMA Hospital Medical Staff Sections.

John D. O'Brien, MD
Chair

Report of the Rural Kentucky Medical Scholarship Fund, Inc

The Rural Kentucky Medical Scholarship Fund, Inc, (RKMSF) attempts to meet the medical needs of the rural population by alleviating the maldistribution of physicians. RKMSF currently administers two worthwhile programs in its efforts to meet this goal.

The first program provides low interest loans to medical students. Any loan recipient who practices primary care medicine in a county in critical need of physicians will be forgiven one loan for each full year of practice in the approved county. Any recipient practicing in a designated rural county facing a primary care physician shortage which is less than critical must repay his/her loans at a discounted interest rate which is determined yearly (currently 3.38%). Interest accrues from the date of the loan until payment is due.

For the school term 1994-95, the RKMSF made scholarship loans to 5 new applicants in the amount of $10,000 each at 3.38% interest, and 15 loans to prior student recipients. A total of $200,000 was expended in scholarship loans for 1994-95. In 1993-94, $260,000 was expended.

Since its inception in 1946, the Rural Kentucky Medical Scholarship Fund has granted 570 loans. There are currently 47 medical students/residents who have received loans from the RKMSF. The loans are granted for an eight-year period. Six recipients are entering residency programs in 1994-95 in family practice, and one has chosen not to enter a primary care residency. Eleven recipients are currently enrolled in residency programs, and three recipients are entering practice in 1994. The remaining 27 recipients are currently in medical school.

There were three recipients who received forgiveness for loans in 1993-94, one recipient is eligible for forgiveness for 1994-95, and nine recipients completed their financial and/or practice obligations in 1993-94.

The second program administered by RKMSF is the Establish Practice Grant Program (EPGP). The EPGP provides money to practicing physicians to assist in paying prior educational loans. For each year a physician in the EPGP practices in a critical county, he/she will be granted $10,000 to be

used toward an educational debt, with a maximum of $40,000 granted per physician.

Two physicians are currently participating in the EPGP. Since its inception in 1989, there have been a total of seven participants in the EPGP. Three physicians have completed their participation, three participants left the program, two taking fellowships out of state and one taking an internship in another specialty. Upon completion of a year of practice, each physician receives a grant of $10,000 to help defray his/her educational debt. The physicians are practicing in the counties of Menifee and Spencer. Currently, there are three vacancies in the Establish Practice Grant Program.

The RKMSF has two main sources of income: interest accrued on the scholarship notes which are paid back or bought out and interest on investments. The average maturity of RKMSF investments is just under two and one-half years, with an average yield of 8.17%.

The Kentucky Medical Association continues to provide its support which greatly contributes to the success of the Fund. The RKMSF, while operated through the KMA, is a separate, nonprofit corporation, having its own Officers and Board of Directors. This report is furnished as an informational item.

Donald R. Stephens, MD
President

End of Consent Calendar Items

Report of the Continuing Medical Education Committee

The work of the Continuing Medical Education Committee has expanded considerably this year. The Committee has continued to meet on a quarterly basis, as well as hold an annual seminar on the continuing medical education accreditation process. The responsibility of the Committee has increased as the number of organizations which the Committee accredits as providers of continuing medical education has tripled over the last two years. As a result, the Committee conducted numerous surveys and resurveys of institutions which applied for accreditation of their CME programs. The Committee serves as the accreditation arm of KMA's CME efforts. In this role, the Committee assists organizations in developing effective CME programs and then monitors organizations' programs through formal surveys. After the surveys, the Committee, in most cases, grants accreditation to organizations so they can, in turn, conduct individual CME programs. Due to the increase in accredited sponsors, the Committee would like to encourage additional KMA members to take an active interest in the proceedings of the Committee and assist in accreditation efforts by serving as site team surveyors.

Surveys were conducted for four institutions which had applied for reaccreditation. All four organizations applying for reaccreditation were approved and granted accreditation periods based on their ability to meet the criteria of the KMA Essentials, which all organizations must demonstrate to become accredited. In addition to the resurveys of previously accredited organizations, ten new organizations submitted applications and were granted surveys. All ten applicants were approved and granted up to a two-year provisional accreditation period, with another survey at the end of the period.

The accreditation process assumes five steps. First, an organization submits an application to the KMA Headquarters Office; the survey team then reviews the application and determines if the organization is ready for a survey; a survey or a reverse site survey is conducted; the survey team formulates a survey report with suggestions for improvement to the organization as well as a recommendation regarding the accreditation period to the CME Committee; and the survey report is subsequently voted on by the Committee as a whole. After the Committee approves an accreditation status, it notifies the organization and informs the organization of the accreditation period. The Committee also requires an interim report from the organization at the midpoint of the accreditation period so the Committee can continue to monitor and assist the organization between surveys.

The Committee undergoes a similar survey process through the Accreditation Council on Continuing Medical Education (ACCME). In this survey process, the ACCME recognizes state medical societies as accreditors of organizations who develop continuing medical education programs. To this end, the Kentucky Medical Association is the only official accreditor of CME organizations in Kentucky. The Committee was resurveyed in July 1993 and was informed of its recognition status in October 1993. The ACCME awarded the Committee its longest recognition period to date — four years — and commended the Committee on its leadership and support for accreditation efforts and also for its documentation and recordkeeping of its work with intrastate providers of CME.

In meeting with representatives from the ACCME survey team, the Committee learned of new suggestions to improve the quality of continuing medical education in Kentucky. The suggestions by the ACCME representatives have been implemented during the course of this year. Those include developing a comprehensive policy and procedure manual on the accreditation process; developing and mailing a CME newsletter to all accredited organizations on a quarterly basis; extending the full accreditation period for organizations up to four years, and the provisional accreditation period up to two years in order to allow organizations more time between surveys to develop their programs fully; revising the appeal mechanism for organizations so that all organizations have due process; offering a consultation service if organizations need additional assistance in establishing a CME program; and offering an expanded seminar with breakout sessions for different tracks based on the knowledge level of CME personnel in Kentucky.

The Committee approved the policy and procedure manual, and it was mailed to all accredited providers of CME in Kentucky as well as to all organizations interested in becoming an accredited provider of CME. The "CME Quarterly" newsletter was initiated in February and helps accredited providers of CME stay abreast of new information on CME from the state and national levels. The appeal mechanism was revised and reviewed by KMA's legal counsel to ensure that it provided due process for an organization appealing an adverse decision.

The Committee held a seminar in conjunction with the Council for Continuing Medical Education on May 26 for CME chairmen and directors and staff of continuing medical education from across the state. The fourth annual seminar increased in attendance from the previous year, as over 75 attendees heard speakers discuss topics on "Surveyor Training: A Mock Site Survey," "Essential #1: The Mission Statement," "AMA PRA Category 1 and 2 CME Credit," "Documentation of the Essentials," "Mandatory CME for Physicians — the Kentucky Regulation," and "The Standards for Commercial Support — Working with Industry." Breakout session topics included "Essential #7 — Joint Sponsorship," "Getting Started — An Overview of the Essentials," "Working With Your CME Committee," and "Remedial/Focused CME." Michael Gannon, Associate Director of CME, American Medical Association, participated on the program and was effective in explaining the difference between Category 1 and 2 CME credit, as well as the benefits of Remedial/Focused CME for physicians.

The Committee continues to have input at the national level regarding CME. Robert R. Goodin, MD, updates the Committee regularly on the business of the AMA Continuing Medical Education Advisory Committee, which he was appointed to in 1992. W. David Hager, MD, Chair, was selected by the ACCME to serve on the newly formed External Monitoring Committee, which is charged with developing and administering a random monitoring process for accredited sponsors of CME. Dr Hager also participated as a speaker on the program of the ACCME/State Medical Society Annual Conference in Chicago on September 12-13, 1993. Dr Hager spoke on "Joint Sponsorship" and Jack Kelly, KMA Staff, spoke on "State Level Cooperatives."

As a result of increased initiatives by the CME Committee to assist organizations in maintaining quality continuing medical education programs in Kentucky, expenses have escalated. In discussions with other state medical associations, it was revealed that many states had implemented an annual fee for accredited organizations. The Committee approved an annual fee to be paid by all accredited organizations in Kentucky up to $200.00 per year, depending on the size of the organization.

The Committee continued its annual solicitation for nominees for the Educational Achievement Award. Since the Committee revised the criteria and the selection process two years ago, the number of nominations has increased annually. Nine nominations were received and considered by the Committee. Three winners were selected by the Committee. The winners were H. David Wilson, MD, Lexington; Larry P. Griffin, MD, Louisville; and W. David Hager, MD, Lexington.

Another major activity of the Committee was overseeing the implementation of Resolution J from the 1992 House of Delegates on mandatory CME

for physicians as a condition of licensure. The Committee forwarded several recommendations to the Kentucky Board of Medical Licensure regarding the implementation of the regulation. The regulation on mandatory CME for physicians was approved in October 1993 and became effective on January 1, 1994, with the beginning of the annual license renewal period for physicians. The regulation requires that all licensed Kentucky physicians obtain 60 hours of continuing medical education credits within a three-year period. Of the 60 hours, 30 of the hours must be in Category 1 credit, and 2 hours must be obtained from a Cabinet for Human Resources approved HIV/AIDS Training Course. The Committee will continue to monitor the regulation as it is met by Kentucky physicians.

Finally, the Committee revised the application for accredited sponsors of continuing medical education. The Committee added a new section to the application on the Standards for Commercial Support since all accredited organizations must maintain compliance with the Standards. The new section asks that organizations document the process used in working with industry in acceptance of support for educational programs. The other addition to the application was under Essential #6 and asks that organizations have input from a representative from the quality assurance/quality improvement department.

The Committee has an additional meeting scheduled for September and anticipates another busy year in 1994-95.

W. David Hager, MD
Chair

Recommendations, Reference Committee 2:
Reference Committee No. 2 reviewed the Report of the Continuing Medical Education Committee. The Committee would like to note that the Continuing Medical Education program underwent resurvey by the ACCME in 1993. The program was awarded the longest period of reaccreditation yet made, four years, and the Committee should be commended for the leadership provided to intrastate providers and other accreditation efforts.

Reference Committee No. 2 recommends that Report No. 17 be filed.

Report of the Physician Manpower Committee

The Physician Manpower Committee met on one occasion this year to review the results of a survey of physicians trained in Kentucky, but who were now practicing out of state. The survey was conducted jointly by the Committee and the Cabinet for Human Resources, and resulted from Resolution K adopted by the 1992 KMA House of Delegates. Resolution K called for the Committee to contact the Cabinet for Human Resources to conduct a survey of physicians trained in Kentucky but who were practicing out of state to determine the reasons why they left the state, if the information was not readily available. After extensive research and discussion with representatives of the medical schools and personnel at the Cabinet for Human Resources, it was determined that the information called for in Resolution K was unavailable and the development of the survey began in the fall of 1993.

The Committee noted that the purpose of the survey was to determine the major reasons why physicians chose to practice outside of Kentucky and identify potential incentives which could be used to attract physicians trained in Kentucky to establish a practice in the state. A 1989 survey of current primary care physicians in Kentucky performed by the Physician Manpower Committee and the Cabinet for Human Resources indicated that personal and professional factors were chief influences on their practice location decisions.

The survey to out-of-state physicians was mailed to physicians who received medical training at the University of Kentucky or University of Louisville medical schools either as a medical student or as a resident. The survey explored five factors important to physicians in choosing a practice location. Those five factors were professional, family, financial, academic, and social/cultural. Among the five primary factors measured, professional reasons rated higher than other factors in influencing practice location decisions. Fifty-five percent of respondents listed availability of practice options relating to professional training, and fifty-three percent indicated level of interaction with other professionals as having some or high influence on their practice location decisions. This finding suggests that, among professional reasons, physicians are more concerned with locating in established practice settings of moderate size that afford the opportunity to practice medicine in a field related to their specific professional training.

The other four factors targeted in the survey showed moderate influence on practice location. Under financial factors, financial compensation had the highest level of influence. Fifty-four percent of respondents rated financial compensation as having some or high decision influence. Family and social/cultural factors had moderate influence with access to cultural activities, interaction with the community, and education for family being the major reasons for practice location under the two categories.

Finally, academic factors had a moderate influence over practice location decisions. The category of most influence indicated under academic factors was residency specialty training. Two open-ended questions allowed respondents to indicate main reasons why they left Kentucky and ways to provide incentives for physicians to practice in Kentucky. The most frequently indicated response to why physicians left Kentucky was perceived lack of opportunities in the residency field in which respondents had trained. The second most popular response was perceived lack of recruitment efforts. The most popular answers indicated under the question of ways physicians can be encouraged to practice in Kentucky were repealing the two percent provider tax and improving the focus of practicing in Kentucky to individuals early in their residency training.

The Committee indicated that the information should be made known to medical professionals in Kentucky and recommended that the Cabinet for Human Resources submit the results of the survey in the form of an article to the *Journal of the Kentucky Medical Association.*

The Committee also reviewed medical education reform under House Bill 250, the health system reform legislation passed by the 1994 Kentucky General Assembly, as well as recent American Medical Association discussion of the issue pertaining to physician workforce.

The Committee noted that the proposals enacted under the medical education reform section in HB 250 will have a major impact upon physician distribution if proper funding is allotted for all programs called for under the legislation. The section creates the Kentucky Health Service at the University of Kentucky and the University of Louisville to create and oversee regional family practice residency programs in community-based sites, one in each congressional district. The section increases the number of family practice residency positions from their current level to a level sufficient to accommodate the medical students in the family practice track of the Kentucky Health Service and caps nonprimary care residency programs at the 1994 level. The Committee noted that the Annual Meeting of the American Medical Association brought discussion concerning caps on residency slots of nonprimary care physicians. The Medical Student Section at the AMA was opposed to the cap on residency programs. The AMA will continue to study and address the cap on residency slots in the United States and emphasized the importance of the need for professional involvement in the limitation of the number of entry-level residency positions.

The medical education reform section also calls for five regional training programs for advanced registered nurse practitioners and physician assistants to assure a combined number of at least 160 graduates per year. This section also establishes a loan repayment program to access federal funds to repay the loans of primary care providers who agree to practice in federally designated health profession shortage areas. Local communities in which a provider will locate will be required to contribute 50% of the state's share of funds required to access federal matching funds, with the state providing the remaining 50%.

Discussion of physician funding of programs called for under medical education reform led to discussion of the designation criteria of the Rural Kentucky Medical Scholarship Fund (RKMSF) for rural and critical counties. The Committee felt that altering the designation criteria for the RKMSF to ensure consistency with the National Health Service Corps criteria would allow for more physicians to locate in rural areas of Kentucky. In addition, as a method to bring more federal matching funds into the state for physician practice start-up grants, it was recommended that funds from the RKMSF's Establish Practice Grant Program be used for matching funds available at the federal level to provide additional funding.

Finally, the Committee addressed other issues of the American Medical Association regarding physician workforce. In an effort to maintain consistency with the AMA terminology, the Committee recommended changing the official name of the Committee from Physician Manpower to Physician Workforce.

The Committee would like to thank the Board of Trustees for being permitted to serve and looks forward to continued work in 1994-95.

Robert R. Goodin, MD
Chair

RECOMMENDATIONS:

1. The Committee recommends that the Cabinet for Human Resources be asked to submit the results of the survey of out-of-state physicians trained in Kentucky in the form of an article to the *Journal of the Kentucky Medical Association.*
2. The Committee recommends that the Rural Kentucky Medical Scholarship Fund (RKMSF) explore the use of the National Health Service Corps criteria of rural and critical counties in order to attract more physicians to practice in rural areas and use the Establish Practice Grant Program funds for federal matching funds available for a state loan repayment program in order to provide an incentive for physicians to locate in Kentucky.
3. The Committee recommends a change in the name of the Committee from Physician Manpower to the Physician Workforce Committee.

Recommendations, Reference Committee 2:
The Reference Committee reviewed the Report of the Physician Manpower Committee and its three Recommendations. The Reference Committee recommends that the report and Recommendations 1, 2, and 3 be adopted.

RESOLUTION B

Economic Credentialing
Northern Kentucky Medical Society

WHEREAS, the implementation of managed care means that physicians and hospitals will need to develop closer working relationships; and

WHEREAS, the result of these relationships may be a form of economic credentialing due to the nature of these contracts; now, therefore, be it

RESOLVED, that KMA policy shall be that prospective quality improvement shall remain the primary purpose of any credentialing process involving physicians; and be it further

RESOLVED, that economic credentialing in the form of hospital-physician exclusive contracts shall not be used to disenfranchise any member(s) of the hospital staff; and be it further

RESOLVED, that physician credentialing in a hospital shall be used to guarantee the quality of care and not be subverted by economic considerations in the form of hospital-physician exclusive contracts that place cost above quality of care.

Recommendations, Reference Committee 2:
Reference Committee No. 2 considered Resolution B, Economic Credentialing, (Northern Kentucky Medical Society) and heard extensive testimony from members of the Northern Kentucky Medical Society, as well as other county societies. The Committee recognized a need for a central repository for instances of economic credentialing and recommends that Resolution B be adopted with an additional resolved to read:

RESOLVED that KMA will establish a repository for instances of economic credentialing and this information be provided to the Hospital Medical Staff Section.

Reference Committee No. 2 recommends Resolution B be adopted as amended.

RESOLUTION K

Smoke-Free Dining
Jefferson County Medical Society

WHEREAS, passive tobacco smoke has been identified as a significantly dangerous carcinogen; and

WHEREAS, restaurants in many states have been designated as totally smoke-free for their patrons' enjoyment and protection; and

WHEREAS, many Kentucky restaurants still do not even have designated nonsmoking areas, thereby placing all patrons at serious risk; now, therefore, be it

RESOLVED, that the Kentucky Medical Association propose to the Kentucky Restaurant Association their joint sponsorship of a voluntary effort to encourage the designation of all Kentucky restaurants as smoke-free, or at least the creation of adequate nonsmoking areas; and be it further

RESOLVED, that county medical societies be encouraged to work with their local restaurant association and area restaurants to further promote the voluntary creation of nonsmoking dining areas.

Recommendations, Reference Committee 2:
Reference Committee No. 2 next considered Resolution K, Smoke-Free Dining, (Jefferson County Medical Society) and recommends that it be adopted.

RESOLUTION O

CME for Retired Physicians
Bowling Green-Warren County Medical Society

WHEREAS, retired physicians have given much of their time and effort to increase the quality of health care throughout the Commonwealth; and

WHEREAS, these physicians are no longer in active practice and/or seeing patients; and

WHEREAS, continuing medical education meetings are very expensive; and

WHEREAS, these physicians no longer have active income to cover these expenses; now, therefore, be it

RESOLVED, that the KMA work with the Commonwealth and the state board of medical licensure to change the requirement for continuing medical education so that retired physicians who are no longer seeing patients would not be required to take continuing medical education courses.

Recommendations, Reference Committee 2:
Reference Committee No. 2 heard discussion on Resolution O, CME for Retired Physicians, (Bowling Green-Warren County Medical Society). It was suggested that all licensed physicians should maintain CME and that all currently licensed physicians should be required to meet and maintain the same standards for licensure.

Reference Committee No. 2 recommends that Resolution O be rejected.

RESOLUTION W

Character Assassination
KMA Board of Trustees

WHEREAS, the *Courier-Journal* printed the names of physicians and purported Medicaid receipts in a startling front page expose; and

WHEREAS, the writers of the article and new editor, through gross, sloppy journalism, failed to research individual names and figures provided by the CHR, and erroneously listed the amounts purported to be paid to physicians by the Medicaid program; and

WHEREAS, the affected and innocent physicians have suffered enormous and unprecedented personal and professional embarrassment with the public and the profession; and

WHEREAS, the *Courier-Journal* ran subsequent "corrective" articles pointing out the discrepancies and wrongful reporting in inconspicuous sections of the paper without personal apology; now, therefore, be it

RESOLVED, that the KMA, on behalf of its affected members, demand a retraction of the story and a public apology to physicians named in the article headlined "Medicaid has First Million-Dollar Doctor" by the *Courier-Journal* on September 8, 1994; and be it further

RESOLVED, that the KMA correspond directly with the Gannett Corporation, parent company of the *Courier-Journal*, requesting an investigation of the inaccuracies in the Medicaid articles and that mechanisms be provided to assure more accurate reporting in the future; and be it further

RESOLVED, that the KMA correspond with the Kentucky Press Association and other journalistic societies to seek ethical review of the Medicaid stories, writers, and editors.

Recommendations, Reference Committee 2:
Reference Committee No. 2 next reviewed Resolution W, Character Assassination, (KMA Board of Trustees) and heard extensive testimony regarding the *Courier Journal*'s articles on Medicaid providers. It was noted that public debate with the print medium will likely be nonproductive.

Reference Committee No. 2 recommends that Resolution W be adopted.

Mr Speaker, Reference Committee No. 2 recommends adoption of the

report of Reference Committee No. 2 as a whole.

Mr Speaker, I would like to thank the other members of the Committee: James F. Beattie, Jr, MD, Bowling Green; H. Michael Oghia, MD, Russell Springs: LeAnn Simmons, Lexington; Daniel W. Varga, MD, Louisville; and Steven L. Willett, MD, Ft. Thomas. I also want to personally thank Denise Prather for her assistance in the preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE NO. 2
Thomas K. Slabaugh, MD, Lexington, Chair
James F. Beattie, Jr, MD, Bowling Green
H. Michael Oghia, MD, Russell Springs
LeAnn Simmons, Lexington (MSS)
Daniel W. Varga, MD, Louisville
Steven L. Willett, MD, Ft. Thomas

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 3

James R. Bean, MD, Lexington, Chair

23. Report of the Maternal Mortality Study Committee
24. Report of the Committee on National Legislative Activities
25. Report of the Committee on State Legislative Activities
26. Report of the Committee on Professional Liability Insurance
27. Report of the Committee on Impaired Physicians
28. Report of the Committee on Care for the Elderly
29. Report of the Public Education Committee
5. Report of the Chair, Board of Trustees, Report of the Ad Hoc Committee to Implement Resolution M (1991), *only*

Resolution A — Provider Tax (Northern Kentucky Medical Society)
Resolution F — House Bill 250 (Bowling Green-Warren County Medical Society)
Resolution G — Copying Patient Records (Bowling Green-Warren County Medical Society)
Resolution H — Provider Tax Awareness (Jefferson County Medical Society)

ITEMS FOR CONSENT

Reference Committee No. 3 reviewed the following items and recommends they be filed as indicated, by the consent of the House, without discussion:

23. Report of the Maternal Mortality Study Committee — filed
24. Report of the Committee on National Legislative Activities — filed
26. Report of the Committee on Professional Liability Insurance — filed
27. Report of the Committee on Impaired Physicians — filed
28. Report of the Committee on Care for the Elderly — filed
29. Report of the Public Education Committee — filed
5. Report of the Chair, Board of Trustees, Report of the Ad Hoc Committee to Implement Resolution M (1991), *only* — filed

Reference Committee No. 3 expresses its appreciation to the authors of the reports which have been filed and recommends the adoption of the Consent Calendar as a whole.

Report of the Maternal Mortality Study Committee

The Maternal Mortality Study Committee of the Kentucky Medical Association met once during the organizational year, September 28, 1993. Five cases were available for study. Considerable detailed discussion took place among the Committee about the complicated situations. After extensive review, the following classifications were made.

MATERNAL MORTALITY STUDY TABLE

Obstetric Direct Preventable	Contributing Factor Large blood loss at time of cesarean with inability to control blood loss from placenta previa. Autopsy performed.
Obstetric Indirect	Head trauma from motor vehicle accident. No autopsy performed.
Obstetric Nonpreventable	Left retroperitoneal hemorrhage. Acute arterial rupture of pelvic vessel. Contributing factor — possible Ehler-Danlos Syndrome. No autopsy performed.
Obstetric Nonpreventable	Hemorrhagic diathesis secondary to Ehler-Danlos Syndrome with: a) epidural hematoma b) massive retroperitoneal hemorrhage. Autopsy performed.
Obstetric Nonpreventable	Amniotic fluid embolism. Autopsy performed.

Two cases are in preparation to be published in the *Journal of the Kentucky Medical Association.*

I would like to say for your information that District V, American College of Obstetricians and Gynecologists, is attempting to look at maternal mortality from a District perspective. A meeting of the Committee was held at the Ritz-Carlton Hotel, Dearborn, Michigan, 12:00-4:00 PM, on February 12, 1994. The following people attended:

James E. Gell, MD, Bloomfield Hills, MI
Roger H. Hertz, MD, Birmingham, MI
Joseph P. Martin, MD, Shaker Heights, OH
Stephen K. Bates, MD, Ontario, Canada
John W. Greene, MD, Lexington, KY
William D. Ragan, MD, Indianapolis, IN

Essentially, this was an organizational meeting and we plan to meet again in a few months.

It is interesting that we in Kentucky and those in Indiana have very accurate figures on maternal mortality, but others do not. In fact, the state of Ohio abandoned its committee in 1985 because of medical-legal problems.

The College feels strongly that we should garner information, for with the problems of teenage pregnancies, AIDS, etc, maternal mortality may be on the rise.

We continue to be indebted for the diligent efforts of John Petry, MD, and his significant contribution in finding and preparing cases for the Study Committee.

John W. Greene, Jr, MD
Chair

Report of the Committee on National Legislative Activities

This has been a particularly busy year for the Committee on National Legislative Activities. The obvious focus on health system reform needs no reiteration. KMA's activities have been closely directed on this issue at the state level with some intensity and, ironically, many of the trends that have been experienced in Kentucky are mirrored at the national level.

The issue of health system reform has evolved from the original comprehensive plan offered by the President, to the current point where several proposals have received popularity periodically which address only specific facets. As of the first of June, there were eight major legislative proposals suggesting a gamut of involvement by the federal government from full control to "arm's length" monitoring. These bills are:

1. HR 3600 (103 cosponsors)/S 1757 (29 cosponsors) — the Clinton Bill

2. HR 3222 (56 cosponsors)/S 1579 (3 cosponsors) — the Cooper/Breaux Managed Competition Act
3. HR 3080 (141 cosponsors)/S 1533 (12 cosponsors) — the Michel Affordable Health Care Now Act
4. S 1770 (21 cosponsors)/HR 3704 (8 cosponsors) — the Chafee Health Equity Access Reform Today Act
5. S 1743 (24 cosponsors)/HR 3698 (24 cosponsors) — the Nickles Consumer Choice and Health Security Act
6. HR 1200 (90 cosponsors)/S 491 (4 cosponsors) — the McDermott/Wellstone American Health Security Act of 1993
7. S 1658 (5 cosponsors)/HR 3486 (121 cosponsors)—the Hatch/Archer Health Care Antitrust Improvements Act
8. HR 3955 (69 cosponsors)—the Rowland Health Reform Consensus Act

As in Kentucky, the key issues have been universal coverage (employer-mandated coverage), funding, and consumer out-of-pocket spending. At the time of publication of this report, the debate appears more congressionally driven than a reaction to or based on public demand because of various funding proposals. It is suggested that there is growing dissatisfaction with Congress on the part of the major payor, that is, the public. Generally, there is public concern about health system reform that will provide the same degree or less coverage now available to the majority of the population at a higher cost than they now pay.

Most all principal theories of health system reform agree on the need for insurance reform provisions, expanded coverage for the currently uninsured, and cost issues, but neither the public nor Congress has agreed on a method to accomplish these things.

Presently, four major committees of jurisdiction have acted on health system reform, while ten others are working on various provisions. Congress is now involved in a self-imposed rush to produce *some* legislation that it hopes can be passed by August, and thus avoid the trial of November elections. At this point, most all provisions do not have sound cost estimates or adequate revenue resources, and all constitute political dynamics not born of need.

Throughout this debate process KMA, through the AMA, has adopted the position that rather than favor any proposal, physicians will finally support a bill that contains basic provisions. These are included in the AMA's "Voice + Choice + Coverage = Support" program. This strategy calls for any reform to assure that physicians have a voice in medical decisions to balance corporate domination of health care, that patients must have freedom to choose their own physicians, that coverage must be available to all Americans, that costs must be constrained by competition and liability reform, and that the final focus must remain on quality of care. This is a reasoned approach to the health care debate because it avoids the parochialism that must result in political negotiations and focuses on patient welfare.

A second major strategy that the AMA has adopted has been support of the Patient Protection Act, S 2196/HR 2547. This bill was introduced to focus on the preeminence of patient welfare in the health system reform debate and follows on the Voice + Choice + Coverage program. The Patient Protection Act would require managed care plans to provide understandable information about covered services, participating physicians, prior authorization, restrictions, and procedures; would guarantee physician input into the formation of medical policy and provide due process for dismissing participating physicians; would require medical review be performed by physicians; would allow patients the option of seeking physician care outside the plan at additional cost; and would provide patients with a choice of types of coverage. Support for the Patient Protection Act is growing and has recently received national media attention, as well as increasing congressional support, based on public demand.

All these activities have been supported through the year by person-to-person letter and telephone contacts with congressmen; through meetings of KMA officers, staff, and individual physician constituents; and through an intensive AMA lobbying effort which, again, mirrors that in operation in Kentucky.

While this work has consumed the bulk of time and energy by organized medicine, other efforts were devoted to physician reforms, National Practitioner Data Bank issues, tobacco issues, and campaign finance reform.

The next few months, and certainly the next year, will probably see a major turning point in medical care in this country based on centralized government care policies. These times are portentous, but equally exciting. Once past all political rhetoric, this year has shown that on focal issues, the public still wants and demands quality care from a physician of choice, and these remain our key concerns and goals.

I would like to thank all the Key Contacts and everyone else who has worked to make their views known. It is also appropriate to relay thanks to our Congressmen who have remained available and responsive to our concerns.

Donald C. Barton, MD
Chair

Report of the Committee on Professional Liability Insurance

The Committee on Professional Liability met on several occasions to discuss ongoing activities in the area of tort reform. The Kentucky Medical Association House of Delegates established the following goals:

1. Amendment to Section 54 of the Kentucky Constitution that would permit the Kentucky General Assembly to place limitations on noneconomic awards (ie, pain, suffering, loss of consortium).
2. Implementation of a patient compensation plan modeled after the Workers' Compensation system.

House Bill 454, which proposed amending Section 54 of the Kentucky Constitution, was introduced by Representative Billy Ray Smith (D), Bowling Green. Unfortunately, House leadership refused to give the bill a hearing before the Elections and Constitution Committee. We did not seek introduction of a patient compensation plan due to the workers' compensation crisis and the tremendous amount of negative legislation which we were forced to address.

We compiled and printed an extensive report and recommendations on tort reform and presented the 150-plus page booklet to every member of the Kentucky General Assembly leadership, along with pertinent committees and their members. Appropriate copies were also forwarded to representatives of Governor Jones' administration. In addition, we drafted a letter outlining KMA's position on tort reform and mailed a copy to every legislator and to members of the executive branch of government.

We were able to scuttle House Bill 428, introduced by Representative Tom Burch (D), Louisville, which would have required physicians to report "any allegation" of malpractice to the Board of Medical Licensure. It also required the physician to report final disposition of the allegation and required the Board to keep written records of the allegations and dispositions and this information would be subject to the "open records" act in Kentucky. House Bill 36, as enacted, provides malpractice coverage for physicians practicing in specified charitable facilities through a $1.00 levy on lawyers' and physicians' licensure fees. In its original format, House Bill 36 would have provided "immunity" for physicians, which obviously is blatantly unconstitutional in Kentucky.

House Bill 250, Health System Reform, sought to address tort reform through arbitration and/or mediation. It is our position that these concepts are only appropriate when either:

1. The decision of the arbitrator is final; or
2. The decision is admissible in future court hearings

The proposals relating to mediation and arbitration, which required virtually every complaint against a physician to be arbitrated were deleted at KMA and KMIC's request.

Both House Bill 250 (Health System Reform) and House Bill 928 (Workers' Compensation Reform) recognize and call for the development, update, and implementation of practice parameters. House Bill 250 includes the following:

"Any health care provider who has followed the practice guidelines approved by the board in the treatment of a patient shall be presumed to have met the appropriate legal standard of care in medical malpractice cases regardless of any unanticipated complication that may thereafter develop or be discovered."

Although we were assured that the Administration would support our efforts for tort reform, including the Constitutional Amendment, support was not forthcoming. So long as the General Assembly, particularly leadership, is dominated by attorneys, our road to true tort reform becomes increasingly difficult. However, we shall continue in our efforts and continue to pursue a true system of justice in the professional liability area. In addition, we

need to garner support from major industries who suffer the same problems we encounter in tort law. On behalf of the Committee we certainly appreciate your continuing support.

Wally O. Montgomery, MD
Chair

Report of the Committee on Impaired Physicians

The Committee on Impaired Physicians has been busier this year than ever before. As procedures become refined, more work is needed to identify, confront, arrange treatment, and monitor aftercare for impaired physicians. As the credibility of the Committee's advocacy grows, so does its responsibility and its work.

A commonly used figure for the prevalence of substance abuse impairment is 10% of any given population. With approximately 8,000 physicians licensed and residing in the state, it can be extrapolated that 800 have some degree of problem, yet the Committee's active casework is nowhere near this number, even though it grows week-by-week. These figures would indicate that the work can only increase. The Committee's efforts are not exclusively devoted to substance abuse impairments, however. This year more cases were identified that involve sexual addiction, psychiatric impairments, and a seemingly growing incidence of so-called "disruptive" behavior.

As the recovery programs of individuals develop, more physicians have become available to assist in the Committee's efforts, and this has been valuable. Likewise, additional members have been added to the Committee directly by the Board of Trustees, partly because of attrition of previous members and partly to help accommodate the increasing workload.

The Committee meets regularly, every other month, but routinely holds meetings of an executive group to deal with ad hoc situations. The Committee also has several subcommittees that informally deal with specific areas. These include liaison with the Alliance, liaison with medical schools and the Board of Medical Licensure, publicity and speakers' efforts, and aftercare activities.

Through the years the Committee has been fortunate in developing effective liaison with the medical schools, and currently representatives from both schools are members of the Committee. This membership is coincidental to their interest and expertise in dealing with impairments. Through this avenue, the Committee has been able to help develop and directly participate in didactic teaching, as well as some curricula changes, and has become directly involved with faculty and in-training physicians. One interesting area now being pursued is working with each medical school to create programs to evaluate the clinical competency of recovering physicians, as well as rehabilitative educational programs.

Relations with the Kentucky Board of Medical Licensure remain positive. Particularly through its aftercare activities, the Committee routinely reports to the Licensure Board on cases the Board has referred, and the Board relies on this information to assist in its consideration of monitoring procedures. Likewise, the Board has been of great assistance in advising the Committee on the depth and appropriate administrative processing of monitoring efforts. In some instances, individuals have attempted to use liaison with the Committee to advance the licensure process. The Committee has refused such efforts and has relied instead on positive, documentable recovery as a means to unencumbered licensure.

The Committee has continued to act as the overseer for the Benevolent Fund on behalf of the Association. The Fund, which has been accumulated from voluntary membership donations, has been used mostly to assist individuals to obtain treatment, although this is not its exclusive purpose. However, with the Fund, the Committee has been able to assure appropriate treatment and to assist the outcome of individuals seeking recovery. Monies expended from the Fund, so far, have all been loans that are repayable, with terms dependent on individual circumstances. Because of the nature of the situation, loans made from the Fund are not the soundest, but benevolence is the overriding concern. Benevolent purposes have been well served, and the Committee does monitor these loans closely.

A good deal of progress has been made in finalizing the development of a free-standing foundation to conduct impaired physician activities. Tax-free designation by the Internal Revenue Service was granted to the Kentucky Physicians Health Foundation, which also was incorporated this year. Grants were received from liability carriers to help fund modest activities, and the Foundation is indebted to these sponsors. The Medical Practice Act was revised by the Kentucky Legislature to recognize impaired physician activities, to allow the development of a formal relationship between the Licensure Board and the Foundation, and to allow the Board to provide some funding.

The Foundation was established, in part, to be able to deal with all licensed Kentucky physicians, regardless of KMA membership, and to provide autonomy for administrative and financial purposes. The Foundation Board of Directors consists of members of the KMA Board of Trustees, the Committee on Impaired Physicians, and the Board of Medical Licensure. In spite of its legal attempt to achieve physical and administrative autonomy, the Foundation will continue to function as KMA impaired physician activities have operated for several years.

It is appropriate to acknowledge the help of many individuals in the efforts of the Committee. Specifically, these include the Committee members, as well as various recovering individuals across the state, and others who have a particular interest in being their "brother's keeper." The Board of Trustees has continued to be strongly supportive of the Committee's efforts, as has the Board of Medical Licensure. Finally, the membership, through its general support and contributions to the Benevolent Fund, has helped all of us provide a crucial forum for the recovery of our suffering peers.

Burns M. Brady, MD
Chair

Report of the Committee on Care for the Elderly

The Committee on Care for the Elderly was established to act as an educational forum for issues relating to geriatric care, to act as a liaison with advocacy groups for the elderly, and to act as a voice for the profession on elderly care matters.

This year most efforts have been focused on health care reform issues, primarily in the legislative arena, at both the state and national levels. This focus monopolized the majority of staff's and the organization's resources, and so the Committee was unable to meet.

Elderly care matters will continue to assume greater importance to the profession, being a strong corollary to health system reform. This aspect of care will be closely monitored in the coming year. The Committee has also identified additional subjects which might be considered. These include long-term care insurance, medication and prescription expenses, end-of-life expenses, and ethical issues related to futility, DNR orders, and advance directives for incompetent patients.

S. Philip Greiver, MD
Chair

Report of the Public Education Committee

The 1993 KMA House of Delegates adopted Resolution H which included the following "Resolveds":

RESOLVED, that the Kentucky Medical Association develop and initiate a permanent and ongoing public education campaign to bring to the attention of the people of the Commonwealth of Kentucky the *positive aspects* of the physicians of the Commonwealth of Kentucky; and be it further

RESOLVED, that this public education campaign should be organized and ongoing on a permanent status until that time that the House of Delegates feels that the campaign is no longer needed; and be it further

RESOLVED, that the educational campaign be reviewed by the Board of Trustees of the KMA on a quarterly basis; and be it further

RESOLVED, that the KMA Bylaws be amended to fund such a public education campaign by increasing Active Member annual dues from $400 to $430.

The KMA Board of Trustees appointed the following members to the Public Education Committee:
Preston P. Nunnelley, MD, Lexington, Chair

Harry W. Carloss, MD, Paducah
Gerald G. Edds, MD, Owensboro
Joseph E. Kutz, MD, Louisville
David C. Liebschutz, MD, Danville
Ross McHenry, MD, Edgewood
G. Irene Minor, MD, Berea
Paul R. Smith, MD, London
Jan Crase, Somerset (KMA Alliance)
Ardis D. Hoven, MD, Lexington, KMA President (Ex-officio)

Every effort was made by the Board of Trustees to assure broad-based representation and, as you can see, every region of the state is represented.

The Committee has scheduled monthly meetings of approximately three hours duration. The first item of business was to develop a Mission Statement. Based on Resolution H and the role of the KMA, the Committee adopted, and the Board of Trustees approved, the following Mission Statement:

> The Public Education Committee is charged with developing and initiating a public education campaign to inform our patients, physicians, the general public, as well as other persons who influence health care in Kentucky, regarding positive aspects of the role physicians play in serving the people of the Commonwealth. The Committee will develop public education programs which enhance the patient/physician relationship and are adaptable for use by county medical societies and/or physicians' offices.

During our initial meeting, the Committee reviewed various PR and patient education campaigns and material developed by KMA in recent years. In addition, the Committee briefly reviewed other state programs and a "spread sheet" prepared to determine various programs that have been completed in other states. We are pleased to report that in most cases KMA has far exceeded other states in developing and implementing a strong PR or patient education program.

Invitations were extended to several PR firms to attend the January Committee meeting and discuss some suggestions for positive imaging of physicians on the local level.

A mailing was directed to all county medical society secretaries informing them of the Committee's goals and seeking a local medical society representative to serve as contact for the Committee. This contact was asked to make suggestions on behalf of the local medical society for local publicity and to name specific local references in the media and press. The contact was also asked to submit five suggestions on how patients, physicians, and the general public could be influenced by the Committee's work. Our response to this request has not been as successful as we would like, but we plan to continue soliciting support at the local society level.

The Committee had a lengthy discussion at its inaugural meeting regarding health system reform. The Committee recommended that a letter be written by the KMA President on behalf of KMA members to all state legislators acknowledging the decision of Franklin Circuit Court on November 23, 1993, that the 2% provider tax imposed on physicians' gross incomes by House Bill 1 is unconstitutional. The Committee noted that physicians have always supported broad-based financial support of health care for the indigent and continue to pledge their resources for health system reform. In addition, the Committee also recommended that a letter be written by the KMA President to all county medical society secretaries encouraging them to write their local legislators and inform them of KMA's continued support of health system reform. Those letters and other forms of communication to the membership were carried out by KMA leadership.

Glen Bastin, Louisville, responded to the Committee's invitation to meet and offer suggestions on how the Committee can best get the message to the public regarding positive aspects of the role physicians play in serving the people of the Commonwealth. In developing public education programs, the Committee decided to concentrate upon those activities which enhance the patient/physician relationship and are adaptable for use by county medical societies and/or physicians' offices. Many suggestions were made by Mr Bastin, ie, use newspapers (for medical columns), local radio, KET, neighborhood civic clubs, PTAs (monthly speakers, etc). Most suggestions centered around the use of local contacts instead of the metropolitan area newspapers and television, but stressed that physicians must be willing to give of their time in order to make the programs successful.

The Committee adopted the following recommendations for initial public education activity:

1. Contract with Glen Bastin to make audio tapes (at a cost of $750 each) on various medical subjects (cost, access, and choice of physician), and distribute tapes to radio stations. All tapes will contain information that the message is sponsored by the Kentucky Medical Association. An interview for the first audio tape entitled "Doctors *DO* Favor Health Care Reform," was conducted with the Committee Chair. The Committee voted to contract with Mr Bastin on a six-month basis to develop other programs to enhance the image of physicians and review the contract after that time.
2. Utilize current KMA staff to work as liaison with Mr Bastin.
3. Establish a statewide phone bank using KMA Alliance to communicate with legislators regarding medical and health-related legislation.
4. Direct a letter to all KMA members informing them of the positive activities of the Committee and the long-term effects to the membership. (The letter was mailed on May 17, 1994.)

The following projects were approved to begin the public education program:

1. Audio News — Create our own "news story." Interviews will be conducted with one or two physicians, prepared as a ready-to-run story for radio, complete with "sound bites," and distributed to each radio station in the state.
2. Quarterly Patient Newsletter — Develop a newsletter for distribution to patients. Newsletters will include "news" stories concerning medical developments, general medical information, feature stories on Kentucky physicians, and the history of medicine. All projects will contain the theme that physicians are patient advocates. Each KMA member will be mailed 10 copies and one copy will be mailed to nonmembers as a recruitment tool. If physicians wish additional copies, they will be made available at production cost.
3. Speakers Bureau/Slide Program — The Committee will actively attempt to place physicians as program presenters for civic clubs and special interest groups. One or more slide programs will be developed to serve as a centerpiece for such appearances. Topics for these presentations will be wide-ranging to include topics such as AIDS, "How to Become a Doctor," health system reform, health care costs, etc. Such appearances will be encouraged to provide an excellent opportunity for "the physician's message."
4. The Routine — The Committee will seek media attention for all physician projects through press releases, pictures, etc.

At its April meeting, the Committee finalized its budget and presented it to the Board of Trustees. On April 14, the Board approved the following budget:

1. Newsletter	
Per Quarter	$ 7,610
Annual Cost	30,440
2. Audio News Release	
Per month	$ 750
Annual Cost	9,000
3. Newspaper column (companion to audio news release)	
Per month	$ 500
Annual cost	6,000
4. Slide Presentation	
Per Presentation	$ 5,000
Annual Cost (4 presentations)	20,000
5. Routine PR (Releases and contacts to promote articles which appear in the *Journal*, Doctor's Day, etc.)	$10,000
6. Miscellaneous	$5,000
TOTAL	$80, 440

Every dollar collected for this program will be utilized for the purpose intended and will be accounted for and published by the Committee on an annual basis.

The Committee approved the initial production of four audio tapes on the following topics: sunburn, sports injuries, dehydration, and the AMA Patient Protection Act. As noted previously, these tapes will be distributed to all radio stations in Kentucky.

A logo entitled "MediScope" and a three-column 11" × 17" layout were selected for the quarterly patient newsletter. The inaugural edition will be mailed by August 1, 1994.

The Committee approved the concept of the KMA Alliance conducting a yearly public relations project on behalf of the medical profession with application being made to the Public Education Committee for funding up to $5,000. The Committee will develop project guidelines to be met prior to approval of the grant.

I want to congratulate the members of this Committee who have worked many days and hours in developing a program which we believe will be meaningful to our patients and have a long-term, positive effect on patient/physician relationships. Committee members have resisted efforts to run newspaper, radio, and television ads. We sought the advice of what we believe to be the top three public relation firms or individuals in Kentucky. All three emphasized the need to develop a theme and to work toward a long-term program that could counter media and political criticisms of the physician community.

We will continue to work with local medical societies and the Alliance to enhance our programs and develop new concepts. On behalf of the members of the Committee, we appreciate the strong support of members of the Board of Trustees and the assistance of many members who have responded to our request for ideas. We look forward to a productive 1994-95 Associational year.

Preston P. Nunnelley, MD
Chair

Report of the Ad Hoc Committee to Implement 1991 Resolution M (Do Not Resuscitate) (Addendum to the 1994 Report of Chair, Board of Trustees)

The Ad Hoc Committee to Implement 1991 Resolution M (Do Not Resuscitate) was formed after the adoption of the Resolution by the 1991 Kentucky Medical Association House of Delegates. Resolution M called for the Kentucky Medical Association to:

1. Work with representatives of appropriate professional groups and organizations, as well as government and regulatory authorities, if necessary, to develop a uniform, coordinated, and rational approach with respect to the terminally ill patient who does not wish to be resuscitated or to receive extraordinary life-prolonging treatment in the pre-hospital environment;
2. Develop a standard prehospital DNR form and to pursue statewide acceptance of this form by means of education;
3. Seek the necessary legislative and regulatory changes to protect the patient's right to self-determination, as well as to protect the activities of those health care professionals who follow such directives;
4. Work toward development of a statewide, standardized, reasonable method for the immediate identification of patients who have a valid DNR order in effect.

The Committee's goal was to seek passage of legislation during the 1994 session of the Kentucky General Assembly. With that in mind and because the Committee felt that in order to pass legislation there must be a common ground among interested organizations, a Coalition was formed by the Committee. The Coalition was made up of a representative from each of the following organizations: KMA's Ad Hoc Committee to Implement Resolution M, CHR's Emergency Medical Services Advisory Committee, Jefferson County Medical Society's Emergency Medical Services Committee (Resolution M's origin), Kentucky Association for Older Persons, Kentucky Association of Health Care Facilities, Kentucky Association of Hospices, Kentucky Home Health Association, Kentucky Hospital Association, and the Kentucky Nurses Association.

The Committee communicated its findings and thoughts on these issues to the 1994 Kentucky General Assembly. The work and research of the Committee and its Coalition was the impetus behind Senate Bill 311, an Act relating to Advance Health Directives that successfully passed the 1994 General Assembly and became law on July 15, 1994. SB 311 meets the charge of 1991 Resolution M and constitutes good health care decision-making legislation for the citizens of the Commonwealth.

Specifically, this legislation allows an adult with decisional capacity to make a written living will directive that:

1. directs the withholding or withdrawal of life-prolonging treatment; or
2. directs the withholding or withdrawal of artificially provided nutrition or hydration; or
3. designates one (1) or more adults as a surrogate or successor surrogate to make health care decisions on behalf of the grantor.

Additionally, notification to any emergency medical responder of a person's wish not to be resuscitated shall be recognized if on a standard form or identification approved by the Kentucky Board of Medical Licensure and the Cabinet for Human Resources.

As Chair, I am grateful to the Committee members for the tremendous amount of time and effort they have expended over the last several years on this sensitive issue. Their efforts did culminate in the passage of meaningful legislation. I also appreciate the interest, time, and input of the Coalition members.

James R. Bean, MD
Chair

END OF CONSENT CALENDAR ITEMS

Report of the Committee on State Legislative Activities

The Committee on State Legislative Activities met formally on one occasion during the year. The first item of business for the Committee was consideration of six Resolutions referred from the 1993 House of Delegates:

Resolution A — Freedom of Choice of Physician

RESOLVED, that the KMA strongly support the patient's freedom of choice of physician; and be it further

RESOLVED, that KMA support and encourage a pluralistic approach to health care delivery that allows patients the option of choosing their own physician.

KMA supported, and the General Assembly adopted, a "patient choice," or "any willing provider," amendment which reads as follows:

> Health Care benefit plans shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and is willing to meet the terms and conditions for participation established by the health benefit plan.

Resolution D — House Bill 1

RESOLVED, that KMA pursue all reasonable legal recourse regarding all onerous aspects of House Bill 1, Second Extra-ordinary Session of the Kentucky General Assembly.

This Resolution was referred to the Committee for information purposes to reaffirm KMA's opposition to the provider tax. The KMA Board of Trustees is managing the legal challenge and the reader is referred to that report for pertinent information.

Resolution M — Cost Containment Subcommittee of the Health Care Reform Task Force

RESOLVED, that the KMA go on record as being opposed to governmental rate-setting of physician's fees, and restriction of freedom of choice by the citizens in selection of health insurance; and be it further

RESOLVED, that the KMA strongly lobby the Legislature to prevent such legislation from being passed; and be it further

RESOLVED, that the KMA pursue all reasonable legal recourse possible, up to and including petitioning the United States Supreme Court, against all Health Care Reform Task Force measures in the present or future which espouse rate control, global budgets, or restrict freedom of choice of insurance carriers and physicians; and be it further

RESOLVED, that in keeping with the Bylaws, the Board of Trustees be authorized to assess the membership amounts necessary to pursue such legal recourse in the event funds available through the KMA Legal Trust Fund are exhausted.

We were successful in deleting from House Bill 250 a section which would have established rate-setting for physicians. In addition, as noted previously, the "any willing provider" section should continue to provide patient freedom of choice, and insurance reforms include a requirement that at least one policy offered must be a "fee for service" plan. Those "Resolveds" relating to the legal challenge are addressed in the Report of the Chair, Board of Trustees.

Resolution O — Use of "EXCESS" Medicaid Funds to Balance the General Budget

RESOLVED, that the Kentucky Medical Association is opposed to shifting Medicaid funds to balance the general budget; and be it further

RESOLVED, that the Kentucky Medical Association pursue all remedies to overturn the provider tax; and be it further

RESOLVED, that the Kentucky Medical Association work to defeat rate-setting and global budgets for health care providers.

An amendment was included in House Bill 250 at KMA's request which addresses the first "Resolved." A summary of that amendment is as follows:

> The secretary of the Finance and Administration Cabinet, after consultation . . . shall on a quarterly basis, certify to the Interim Committee on Appropriations and Revenue the general fund savings realized from . . . this Act and any other procedures adopted . . . to control the cost of health care. The amount certified by the secretary . . . shall be transferred to a trust account to be utilized by the secretary of CHR to provide health care coverage for additional categories of citizens, but the funds in the trust account shall not be spent until appropriated by the General Assembly.

Once again, those "Resolveds" relating to "legal action" are being managed by the KMA Board of Trustees. As noted previously, sections relating to global budgets and rate-setting were deleted from House Bill 250.

Resolution C — Physician Assistants

RESOLVED, that the Kentucky Medical Association continues to support the practice of physicians and physician assistants in which PAs are supervised by licensed physicians and be it further

RESOLVED, that the Kentucky Medical Association endorses legislation that allows licensed physicians who are approved to supervise physician assistants the authority to delegate to PAs in their practice the prescribing, dispensing, and ordering of nonscheduled medications in accordance with the discretion and responsible oversight of the supervising physician; the experience, training, and scope of practice of the physician assistant; and the needs of the patients served by the practice.

House Bill 250, as originally introduced, did not include PA legislation. However, it was included in the amended version as adopted by the House of Representatives. In addition, House Bill 323 was introduced, which met KMA house of Delegates PA policy. The amended PA section in House Bill 250 was caught up in the controversial ARNP and optometry sections and KMA was forced to delete, along with ARNP and optometry sections, all reference to PAs in HB 250. The Senate Health and Welfare Committee, in a punitive measure, "re-amended" the ARNP and optometry language to HB 323 and the bill remained in the Senate Rules Committee until the final day of the session.

Resolution N — Nursing Home Beds

RESOLVED, that the Kentucky Medical Association address the issue of the limited supply of extended care beds in Kentucky with full vigor and strongly recommend to the Legislative Committee action to bring about resolution of this problem and to devise a master plan to address this issue in the 1990s; and be it further

RESOLVED, that the Kentucky Medical Association recommend to the Kentucky State Legislature this plan of action to help prevent further crises in the delivery of medical care.

An attempt was made to address the problem of bed shortages through an amendment to HB 250 which would have removed nursing home bed control from the state Certificate of Need. However, as physicians are aware, a large amount of nursing home reimbursement comes from Medicaid. With financial shortfalls in Medicaid and strong resistance from the General Assembly and the Administration, this amendment failed. Due to the unbelievable workload and added stress of the session, we were unable to study this problem. However, the Committee will work during the interim period of the General Assembly to seek some resolution or proposal to address this problem. We should complete the study and present recommendations to the 1995 House of Delegates.

During the 1994 session of the Kentucky General Assembly, KMA followed 176 bills, with most efforts devoted to HB 127 (Medicaid Fraud and Abuse), HB 250 (Health System Reform), HB 928 (Workers' Compensation), SB 37 (Medicaid Fraud and Abuse), SB 177 (Medical Licensure/Impaired Physicians), and SB 311 (Advance Directives).

As you are aware, HB 250, Health System Reform, as amended by both the House Health and Welfare Committee and the Appropriations and Revenue Committee and adopted by the House, included the provider tax; permitted ARNPs to practice independently and prescribe all legend drugs with a 24-48 hour limit on controlled substances; and allowed optometrists to prescribe oral medications and injections. HB 250 established a five-member Health Policy Board and permitted it to establish rate-setting mechanisms, utilization targets, annual budgets, and revenue caps; allowed the Board to review the reasonableness and certify costs and charges of each health care provider; established fines anywhere from $100 to $1,000; and authorized review of reimbursement rates for physicians and other onerous provisions.

Upon arrival in the Senate, the bill was referred to the Senate Appropriations and Revenue Committee which eliminated most House provisions, with the exception of the tax, and replaced them with SB 17 and SB 97, more conservative versions introduced by both Democrats and Republicans. The A & R Committee considered over 100 amendments to the revised HB 250. KMA was successful in amending the bill in the Senate Committee to rewrite fraud and abuse provisions to conform with federal regulations. Provisions relating to the prescriptive authority of optometrists and nurse practitioners were deleted at KMA's recommendation. Numerous other clarification amendments were approved by the Committee in accord with KMA policy.

The bill then went to the Senate floor where it attracted 89 amendments. On the Senate floor, provisions relating to rate-setting were removed by amendments. Changes were made in the "generalist physician" clause to conform with accepted medical standards and the "any willing provider" or "patient choice" amendment was adopted. The Senate also amended the bill to permit the establishment of provider-sponsored integrated delivery networks which meet all insurance requirements. KMA made two intense efforts to (1) delete the tax; (2) delete the Health Policy Board. We were narrowly defeated 20-18 on both amendments. The bill then passed on a 20-18 vote and returned to the House where it remained until April 1. On April 1, the final night of the session, the bill was referred to a Free Conference Committee where several changes were made.

As you are aware, controversy over the budget and removal of construction projects created the controversy which raged the final day. HB 250 became a pawn to throw the budget out of balance. During the Conference Committee, a provision was added that stated, "If Medicaid funding is insufficient to provide benefits to eligible recipients, it is the General Assembly's intent not to cut services or the number of recipients. There shall be a reduction in the provider reimbursements for covered services for the purpose of financing such provisions." (Budget [HB 302] was vetoed by the Governor.)

I doubt this maneuver came as a surprise. Historically, the State has reduced Medicaid reimbursement during budget deficits to comply with constitutional requirements of a balanced budget. However, federal law, particularly the "Boren Amendment," requires Medicaid to reimburse services for pediatrics and obstetrics at customary rates. In addition, a successful federal suit by the Arkansas Medical Society requires Medicaid to follow certain regulatory procedures before slashing reimbursement.

We fully expect the Governor and some members of the General Assembly to continue their efforts to raise the provider tax in future years. During the session, Governor Jones floated increases from 2.75% up to 6% on the physician side. We must be constantly on guard and be ready to quickly address this threat.

Despite the health system reform headlines, a major battle was taking place in the General Assembly to reform an almost bankrupt Workers' Compensation program. HB 928, the omnibus Workers' Compensation reform legislation, was adopted calling for numerous changes in the management of Workers' Compensation. As originally drafted, the bill would have established physicians' fees at 115% of Medicare reimbursement. After intense lobbying, that provision was amended to require the Workers' Compensation Board to contract with consultants and recommend regulations to effect a 25% reduction in *total medical costs* within the program. Under this scenario, the Board must review *global medical costs* rather than simply focusing upon physician and hospital reimbursement. The legislation will also establish a deposition fee schedule, provide for managed care within Workers' Compensation, and establish self-referral restrictions based on federal law. Strong managed care with gatekeeper provisions are recommended and provisions allowing patients to obtain their medical records are included.

Officers and staff put in many hours to alter the original Medicaid fraud and abuse bills, SB 37 and HB 127. Provisions supported by the sponsors and LRC staff relating to fines and self-referral restrictions were very difficult to resolve. The sponsors eventually accepted KMA's recommendation, and both Chambers adopted "Stark II," or federal provisions, as they relate to self-referral. The Administration and General Assembly are predicting massive savings as a result of these changes. Everyone should be alert and aware of this law and subsequent regulations relating to these bills. A "storm trooper" mentality may develop within the Medicaid Division and Attorney General's office as they attempt to capture the hundreds of millions of savings that have been liberally predicted.

Finally, SB 177, jointly proposed by the Board of Medical Licensure (BML) and KMA to strengthen the BML and incorporate the Impaired Physicians Committee under the BML, was adopted. SB 311, relating to advance health directives, was also adopted. The legislation unifies the health care surrogate and living will acts, clarifying the complementary nature of the two concepts: to indicate health care choices in advance as much as possible and to designate a trusted individual familiar with one's values to interpret those choices in the actual situation and make choices for unforeseen circumstances. After many years of struggling, the mandated seat belt law was adopted by the General Assembly. As usual, we worked to defeat numerous proposals which would have an adverse effect upon patient care and professional practice standards.

KMA made a massive effort to keep Kentucky physicians informed during the interim period, Special Session, and the regular 1994 session of the General Assembly. Since September 1993 we have printed and mailed over 30 direct newsletters and, on one occasion, three mailings in one week during the Session. In addition, we held a "KMA Day" in Frankfort for all physicians. After the session, we conducted a series of seminars on health system reform in all 15 KMA districts.

A special thanks is extended to the membership for its involvement in the 1994 session. We need to maintain that intensity as the health system reform battle moves to the regulatory phase. Finally, thanks to the seven physician members of the Quick Action Committee who met in Frankfort on a weekly basis. Special appreciation is due President Ardis D. Hoven, MD, for her guidance, quick grasp of the issues, and the highly professional bearing she brings to the Presidency of KMA. Her testimony on several occasions during the session, under extenuating circumstances, was outstanding.

Wally O. Montgomery, MD
Chair

Recommendations, Reference Committee 3:

Reference Committee No. 3 reviewed the Report of the Committee on State Legislative Activities and would like to commend Wally O. Montgomery, MD, for his particular contribution of time and involvement during the legislative session.

Reference Committee No. 3 recommends the Report of the Committee on State Legislative Activities be filed.

RESOLUTION A

Provider Tax
Northern Kentucky Medical Society

WHEREAS, the 1994 Extraordinary Session of the General Assembly altered the language defining a provider tax to help fund Medicaid; and

WHEREAS, the new language remains silent about passing through this provider tax to consumers of health care services; and

WHEREAS, individual members of the General Assembly stated that the new language was created to make pass-through permissible; now, therefore, be it

RESOLVED, that the Kentucky Medical Association shall design and disseminate a strategy to allow physician providers to pass through the tax imposed on physician gross revenues by the 1994 House Bill 250; and be it further

RESOLVED, that KMA shall design and implement a strategic plan that will inform the Kentucky consumers of health care services, our patients, who in state government (the Governor, the legislators who voted for House Bill 250, and other state employees who facilitated passage of House Bill 250), are responsible for patients incurring a surcharge of 2% of the cost of their medical service to pay for the Medicaid program; and be it further

RESOLVED, that KMA shall design and disseminate printed material and other promotional material that identifies the elected officials who supported the taxing provisions of House Bill 250 and specifically states how consumers of health services, our patients, can voice their concern for this "sick" tax to those responsible individuals; and be it further

RESOLVED, that KMA develop and disseminate a legislative strategy to improve the likelihood that the 1996 Legislature will rescind the so-called provider tax, or "sick" tax, as a method of funding the Medicaid budget; and be it further

RESOLVED, that KMA shall develop, finance, and implement a process to test the legality of passing through the provider tax created by House Bill 250 to the various patient constituencies or the constituencies' payors (including Medicare, Medicaid, private pay, fee-for-service, discounted fee-for-service, prepaid, and other managed care contracted arrangement).

Recommendations, Reference Committee 3:

Reference Committee No. 3 reviewed Resolution A, Provider Tax, submitted by the Northern Kentucky Medical Society and considered the recommendation of the Board of Trustees. The Reference Committee heard testimony in opposition to the provider tax, testimony in favor of determining if the tax could be passed through to the consumer, and testimony in favor of testing the legality of the pass-through of the tax. However, the Committee also heard concern for the expense involved.

Reference Committee No. 3 recommends the adoption of Resolution A with the exception of the last "Resolved" and recommends the last "Resolved" be referred to the Board of Trustees for study. The "Resolved" recommended for study by the Board is as follows:

RESOLVED, that KMA shall develop, finance, and implement a process to test the legality of passing through the provider tax created by House Bill 250 to the various patient constituencies or the constituencies' payors (including Medicare, Medicaid, private pay, fee-for-service, discounted fee-for-service, prepaid, and other managed care contracted arrangement).

RESOLUTION F

House Bill 250
Bowling Green-Warren County Medical Society

WHEREAS, House Bill 250 seeks to control all aspects of health care; and

WHEREAS, one of the major provisions of House Bill 250 is to create a Health Policy Board to implement said control; and

WHEREAS, one of the major provisions of the Health Policy Board allows search and seizure of private patient records by government agencies without the patient's permission; and

WHEREAS, the Policy Board may establish "types" of insurance plans to be offered to all Kentuckians; and

WHEREAS, this may restrict the types of policy available to citizens of Kentucky; now, therefore, be it

RESOLVED, that the Kentucky Medical Association work steadfastly to overturn House Bill 250, up to and including petitioning of the United States Supreme Court, especially regarding those portions related to confidentiality, insurance, and health policy reform.

RESOLUTION G

Copying Patient Records
Bowling Green-Warren County Medical Society

WHEREAS, House Bill 250 requires physicians to copy free of charge medical records of any patient who makes such a request; and

WHEREAS, in some cases this activity may be an extremely expensive investment in staff time and money; now, therefore, be it

RESOLVED, that the KMA work to overturn the onerous requirement of HB 250 to copy patient medical records without reimbursement.

Recommendations, Reference Committee 3:

Reference Committee No. 3 next heard testimony from representatives supporting Resolution F and Resolution G, and received input from the Board of Trustees. The Reference Committee feels that both Resolutions address elements of House Bill 250, particularly confidentiality of patient records, photocopying patient records without reimbursement, and standardized insurance plans. With the agreement of the authors of Resolution F and

Resolution G, Reference Committee No. 3 developed the following substitute Resolution:

RESOLVED, that the Kentucky Medical Association work steadfastly, both legislatively and legally, to overturn the onerous portions of HB 250, especially regarding those portions related to patient record confidentiality, reproduction of patient records without reimbursement, and standardized insurance plans.

Reference Committee No. 3 recommends that the substitute Resolution be adopted in lieu of Resolution F and Resolution G.

The motion was seconded from the floor. James F. Beattie, Jr, MD, Delegate from the Warren County Medical Society and a member of the Rural Caucus, was recognized, who made a motion to amend the Reference Committee substitute Resolution to read as follows:

RESOLVED, that the Kentucky Medical Association work steadfastly, by all reasonable legislative and legal methods, up to and including petitioning the US Supreme Court, to overturn the onerous portions of HB 250, especially regarding those portions related to patient record confidentiality, reproduction of patient records without reimbursement, and standardized insurance plans.

The motion was seconded from the floor and carried.

RESOLUTION H

Provider Tax Awareness
Jefferson County Medical Society

WHEREAS, House Bill 250 adopted by the 1994 Kentucky General Assembly perpetuates the 2% tax on physicians' gross incomes; and

WHEREAS, HB 250 no longer specifically prohibits the passing along of this tax to the patient; and

WHEREAS, the KMA has researched this subject and found it complex and difficult, if not impossible, to pass through the tax; and

WHEREAS, patients and the news media are becoming aware of newly imposed "sick" taxes due to the twenty-five cent per prescription tax; now, therefore, be it

RESOLVED, that the KMA encourage all member physicians to foster public awareness and grass-roots opposition to the 2% provider tax, by placing the following statement on all patient invoices and related communications:

The cost of providing your care has been increased by a 2% tax imposed on doctors by the Kentucky General Assembly to fund Medicaid in Kentucky. If you object to this tax, please contact your state representative and senator.

Recommendations, Reference Committee 3:

Reference Committee No. 3 next reviewed Resolution H, Provider Tax Awareness, submitted by the Jefferson County Medical Society.

Reference Committee No. 3 recommends that Resolution H be adopted.

Mr Speaker, Reference Committee No. 3 recommends the adoption of the Report of Reference Committee No. 3 as a whole, as amended.

Mr Speaker, I wish to thank the other members of Reference Committee No. 3 for their participation in the review of these issues. They are: Jack C. Blackstone, Jr, MD, Owensboro; Thomas E. Bunnel, MD, Erlanger; Marcia L. Cave, MD, Henderson; Mark A. Cepela, MD, Edgewood; and B. Thomas Harter, Jr, MD, Louisville. Reference Committee No. 3 would also like to express its appreciation to Jeanette Thompson for her assistance in preparing this report.

Respectfully submitted,
REFERENCE COMMITTEE NO. 3
James R. Bean, MD, Lexington, Chair
Jack C. Blackstone, Jr, MD, Owensboro
Thomas E. Bunnell, MD, Erlanger
Marcia L. Cave, MD, Henderson
Mark A. Cepela, MD, Edgewood
B. Thomas Harter, Jr, MD, Louisville

Report of the Chair

KEMPAC Board of Directors

Thank you Mr Speaker, Fellow Delegates, and guests.

Over the years persistent attacks upon Political Action Committees has taken its toll, at least on the State level. With the passage of PAC reform in 1992, Kentucky Physicians were eyewitnesses to, and experienced first hand, the dramatic impact it had on medicine's 1994 legislative agenda. Prior to 1992 it was fairly common for KEMPAC to contribute $8,000 to a state Senate or House campaign. The 1992 Kentucky General Assembly limited contributions to state candidates for the House and Senate to $500 per race. Suddenly, legislators had to rely on individuals rather than PAC's for campaign dollars. Unfortunately, individual physicians as usual failed to stand in the breech and we paid dearly. This act effectively shut the door to KEMPAC's ability to affect legislative campaigns. AMPAC/KEMPAC was established in the mid 60's to counter labor industry PACs which were pushing for National Health Insurance. AMPAC/KEMPAC sought out candidates who shared Physicians political and economic philosophies and financially assisted them in their campaigns.

Many of us might be inclined to believe that PACs have a disproportionate influence upon democratic government. While you might think that PACs roles should be diminished, there is a down side.

Historically, less than 15% of Kentucky physicians are members of KEMPAC. This small cadre of Physicians pumps approximately $100,000 into Kentucky General Assembly biennial campaigns. KEMPAC was a *big time* player, exceeded only by KEA. Secondly, this same small group also dug into their own pockets and personally helped candidates. Coupled with a renewed and revitalized state legislative program in the mid 80's, KMA and KEMPAC in tandem became a driving force in Frankfort.

PAC reforms, along with Boptrot, legislative ethics, and the media's distaste for special interests, poses enormous obstacles for the medical profession. Secondly, the General Assembly remains on course in its drive for independence from the Executive Branch. When the three equal branches of Government, Judicial, Executive, and Legislative are compared, most observers believe the Legislative Branch has become dominant. Therefore, while the General Assembly grows in power and stature, the mechanisms we have relied upon the participate in determining who sits in that body has been diminished.

The third factor and the one most devastating to medicine is physicians' disinterest in politics, particularly races for the General Assembly. While a few physicians will dig into their pockets to support candidates for Congress, U.S. Senate, or Governor, relatively few physicians contribute to legislative races. The old saying "Washington Debates while Frankfort Legislates" sure made its presence felt in 1994. Wally Montgomery, our legislative Chair has warned us for years that the immediate threat to medicine was in the halls of state government rather than Congress. Obviously we ignored him then and I'm not sure it's sunk in yet. For instance, 100 of 100 House members and 19 of 38 Senators are up for election. Other than a few races, physicians' activity has been nonexistent. The most compelling example of this profession's attitude can be best described by the unbelievable drop in KEMPAC membership this year.

Finally, we must come to grips with the fact that business and agriculture are not on our side. Their only concern is reducing health costs and as we found out during the 1994 Session, both in Health Reform and Workers Compensation, Doctors were isolated. Employers wanted cuts in medical costs and didn't care how it affected Providers. Both the State and local Chambers of Commerce actively worked for HB 250 and, in particular, supported even stronger reductions in Physician reimbursement under workers compensation.

The forces controlling Frankfort and Washington threatening to turn our medical system upside down are persistent, and like the poor, "will always be with us". The sooner we understand that our foes are formidable, well financed and managed, and are here to stay, the quicker we can go on the offense.

The direction and future activity of KEMPAC, like medicine, is in transformation. While KEMPAC will continue to financially support candidates, most of our resources must be directed toward political education.

1. First, all physicians should know how their Legislators vote. Full disclosure and reports should be passed along to individual physicians and County Medical Societies on each Legislator's voting record.
2. Second, and most importantly, KEMPAC must begin developing programs to:
   A. Develop training programs and teach physicians and spouses how to run for public office. We need to set a target of 3-5 physicians in each House in the next 5 years. On the local level, we need to find a way to financially support doctors who want to serve but can't abandon their practices.

B. Design programs geared toward teaching physicians and spouses how to conduct political campaigns. In other words, how to be a campaign chairman.
C. Teach physicians how to get involved in political campaigns. In addition, we need to know what we can — and can not do with our patient base.
D. Form a special organization of physicians supporting physician campaigns. There are several legislators we need to target.

We have traditionally kept patients out of our battles. However, House bill 250, Workers Compensation Reform, Provider Taxes, Medicaid reductions and various insurance schemes directly affect them — and — they have not been informed about the changes.

Our future is tonight — NOW — The cliché "Medicine at the Crossroads" is a reality — or more likely — a nightmare in Kentucky. Medicine as we know it — particularly the Physician/Patient relationship, is threatened. We can complain — we can blame our legal counsel and our lobbyists — we can blame AMA and KMA — we can write letters — we can make phone calls — we can visit Washington and Frankfort — we can even threaten all of the above. Unfortunately doctors — unless you contributed to the campaign — worked for the election or re-election — took the time to get to know the office holder — all your activities may be in vain. Despite the fact that two Senators, one a physician and member of KMA, a top executive in a major Louisville hospital voted against KMA in the Senate, we still only lost on HB 250 and the tax on a 20-18 vote. One vote more and we could have killed the bill. Here is a prime example of how one vote can affect an issue and points strongly to the fact that if only we had been successful in one more Senatorial District?

WE CAN SURVIVE. We can turn this debacle around. However, to be a force, we must return to grassroots politics and recognize that participation in politics is required CME for doctors. It won't be easy but, I'm confident it can be done.

Medicine has been my life. I am proud to be a physician and despite all the turmoil, the joy and challenge of patient care is still exciting. Just as our predecessors paved the way for us, we owe the sons and daughters who follow, the same wonderful opportunity to practice medicine. The only way we can have an impact upon politics is to jump in — I intend to continue doing just that.

On behalf of the KEMPAC Board, I want to thank you delegates and the KMA Board of Trustees, and say that it has been my pleasure to have had the opportunity to serve as KEMPAC Chair.

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 4

C. Randolph Schrodt, Jr, MD, Louisville, Chair

30. Report of the Committee on Medical Insurance and Prepayment Plans
31. Report of the Committee on Claims and Utilization Review
32. Report of the PRO Advisory Committee
33. Report of the Committee to Investigate Changing Trends in Medicine
34. Report of the Young Physicians Steering Committee
35. Report of the Resident Physicians Section
36. Report of the Medical Student Section
37. Report of the Physician Organization Study Committee

Resolution C — Impairment Prevention and Education in the Training Years (Resident Physicians Section)
Resolution N — Primary Care During Perinatal Period (Fayette County Medical Society)
Resolution R — Ophthalmologists as Primary Eyecare Providers (Fayette County Medical Society)
Resolution S — Use of Laser Therapy (Fayette County Medical Society)

ITEMS FOR CONSENT

Reference Committee No. 4 reviewed the following items and recommends they be filed as indicated, by consent of the House, without discussion:

30. Report of the Committee on Medical Insurance and Prepayment Plans — filed
31. Report of the Committee on Claims and Utilization Review — filed
32. Report of the PRO Advisory Committee — filed
34. Report of the Young Physicians Steering Committee — filed
35. Report of the Resident Physicians Section — filed
36. Report of the Medical Student Section — filed

Mr Speaker, Reference Committee No. 4 recommends adoption of the Consent Calendar as a whole.

Reference Committee No. 4 would like to express its appreciation to the authors of the reports which have been filed for their time and effort spent in gathering this information for the House of Delegates.

Report of the Committee on Medical Insurance and Prepayment Plans

The Committee held two formal meetings this year. In the interim, your Chair and staff met four times and participated in two conference calls with Kentucky Blue Cross and Blue Shield senior executives in an effort to make the KMA-endorsed Blue Cross and Blue Shield plan more attractive.

The Committee has been concerned with the plan because it is not growing in size, which would spread our risk over more people. In addition, the average age of the group is 51 years which contributes to our premium increases, since older populations tend to use more services. Our goals were to develop a program that was attractive in terms of premiums and benefits and would bring more members into the group coverage.

This summer, a fourth option was added to the plans offered through KMA. This new addition includes a physician network, tiered rating (rates for an individual, parent and child [children], husband and wife, and family), age rating, and a mental health services network. It will be marketed to physicians currently not participating in any KMA-endorsed plan and to nonmembers of KMA. Nonmembers will be required to join the Association to be eligible for coverage. We are hopeful this new offering will help our plan premiums stabilize. The plan will be reevaluated at renewal next February.

The Committee has also discussed developing a plan based on the concept of professional courtesy. Professional courtesy at one time meant that physicians did not charge other physicians or their families, and often their staffs. Professional courtesy now often means that the providing physician will accept whatever the physician patient's coverage pays.

The Committee is exploring the feasibility of offering a plan where KMA members would accept a fee reduction on the order of 50%, or a specific fee schedule of a similar reduction, in return for a premium that is 20-30% less than they are paying now. There would be no payment for in-office services. The reduced fee for nonoffice services would generally cover overhead, but essentially remove the professional component of the charge. The plan would cover physicians and their family members, their staffs and family members, and would require a separate participating physician agreement.

The Committee recognizes this is a dramatic departure from the traditional plans offered in the past. Yet, we believe it offers a potential benefit to members that is unavailable otherwise and is based on the long-standing medical tradition of professional courtesy.

The Committee will continue to develop this concept and bring specific recommendations to the Board of Trustees when and if such recommendations are appropriate. In addition, the Committee will continue to examine plan options in order to provide the best possible coverage at the most reasonable price.

In addition to the Committee's work on the KMA group insurance plan, the Committee considered the following issues as well.

Resolution J — Resolution J, adopted by the 1993 KMA House of Delegates, was referred to our Committee. Resolution J noted the increasing frequency of insurance carriers to deny payment to physicians serving as assistant surgeons in the operating room. The Resolution called on the Medical Insurance and Prepayment Plans Committee to collect guidelines on the appropriate use of physicians as assistants at surgery already developed by medical specialty societies, and report the results of its study to the Board of Trustees and recommend how the information gathered could best be utilized.

Staff was asked to contact major national surgical societies to obtain

copies of their guidelines on the appropriate use of physicians as assistants at surgery. Surprisingly, several major national surgical groups reported that they do not have guidelines. The following is a summary of the guidelines sent to the Committee:

The American Association of Neurological Surgeons position is:

> The neurosurgeon in charge of a case is best able to determine the level of competence required by a surgical assistant and should have the responsibility of choosing an appropriate assistant surgeon or surgical assistant. The assistant (whether a physician, physician assistant, or other) should receive separate reimbursement commensurate with his/her talent and training.

The American Academy of Orthopaedic Surgeons suggests the decision to use an assistant surgeon be based on the characteristics of the patient (risk and complexity of the surgery, patient condition, and age), the characteristics of the operation, and the characteristics of the operating environment, and comes to the following conclusion:

> While consensus seems to exist on the variables to be considered in determining the need for a trained first assistant, little consistency exists as to the most appropriate type of assistant.
>
> Some orthopaedists routinely use technical assistants in cases for which other orthopaedists prefer a second orthopaedist. At this time, no national standards exist. While lists of procedures might seem useful, it should be recognized that such lists can never be all inclusive. The ultimate decision as to the need for a surgical assistant must remain with the operating surgeon.

The American Medical Association Policy on Assistants at Surgery states:

> The American Medical Association 1) opposes any effort by Medicare or any other third party payor to limit payment for medically necessary care, especially in the area of assistants at surgery; 2) supports and participates in, as appropriate, the efforts of state and specialty societies to develop guidelines for appropriate use of physicians as assistants at surgery; and 3) continues to oppose and seek regulatory and/or legislative relief from the discriminatory downgrading or elimination of Medicare payments for assistants at surgery.

While there are sources regarding the appropriate use of physicians as assistants in surgery, their usefulness as an educational tool as suggested in Resolution J is less clear. The Committee intends to discuss this matter further in an effort to recommend a way to implement the Resolution in a useful, cost-efficient manner.

Resolution K—Resolution K was adopted by the House of Delegates and referred to the Committee by the Board of Trustees. The Resolution calls for the Committee to work with the insurance community to develop an efficient method of communication between the medical profession and the insurance industry at the state level.

The Committee has made an ongoing effort to develop a liaison with carriers over the years. Currently, there are over 400 carriers licensed to sell health insurance in Kentucky. Only two major carriers, Kentucky Blue Cross and Blue Shield and Humana, are headquartered in Kentucky. Due to the merger of the Kentucky and Indiana Blue Cross and Blue Shield plans, one might argue that Blue Cross and Blue Shield is no longer headquartered in Kentucky.

Over the years, as the Committee tried to increase communications with carriers, it found it impossible to meet with representatives of every licensed insurance company. Thus, we turned to the Health Insurance Association of America, a trade group representing the major for-profit insurance companies. The local HIAA representative would be located and invited to meet with the Committee, usually to respond to a complaint from a KMA member over a specific policy of one or more companies. The representative would come to our meeting, politely listen to what we had to say, leave, and nothing would happen. We learned that unless we could meet with the company decision makers or those with direct access to decision makers, meetings with HIAA on a state level were not productive.

In spite of these limitations, the Committee believes the intent of Resolution K has merit and plans to invite representatives of the five largest carriers in Kentucky to meet with us in the future.

As Chair of the Committee, I appreciate the continuing participation of the Committee members.

Donald R. Neel, MD
Chair

Report of the Committee on Claims and Utilization Review

Claims and Utilization Review Committee activities have focused almost exclusively this year at the county and trustee district level. As managed care plans continue to grow and have essentially become dominant, there is less and less need for autonomous physician review. However, the Committee and this Association remain committed to review of medical issues by practicing physicians.

It is valid that an organized role for physician review at the medical association level exists, and some steps are being taken to identify that role. Fraud and abuse issues received considerable attention by the Kentucky General Assembly this year and constitute a major provision of the health reform bill enacted. These concerns are specifically related to the Medicaid program. Through the Board of Trustees, the Association's capability and willingness to address fraud and abuse matters have been relayed to the Cabinet for Human Resources. While statistics can definitely show trends, actual incidences of care can only be properly evaluated, again, by practicing physicians, and it is strongly hoped that any fraud and abuse efforts conducted by the state include organized physician review.

The Committee is also evaluating a possible role for review efforts in identifying physician practice patterns and developing review/educational opportunities through the Medicare Part B carrier office. Discussions with the Medicare carrier representatives have begun to this end. Through the offices of the medical director, the Committee is exploring a possibility of focusing on specific procedures and treatment patterns that can be improved through ongoing review and specifically designed correctional programs. This will be pursued further.

As other review matters develop, the Committee will give attention to them as needed and appreciates the support of the Board of Trustees.

K. Thomas Reichard, MD
Chair

Report of the PRO Advisory Committee

The Professional Review Organization Advisory Committee continued its efforts this year to monitor the activities of the Kentucky Medical Review Organization, to act as liaison between the PRO and the profession, and to consider information that would be of interest to the members relating to PRO activities.

KMA was approached again this year by representatives of the PRO seeking individuals who would assist in review activities. The Committee affirmed KMA's position that review of medical practice in Kentucky should be undertaken by Kentucky physicians, but that KMA does not endorse specific review actions. The Committee does feel this is an important concept, and would urge all members to become involved in review based on individual interest.

The PRO developed guidelines for medical records documentation, which the Committee reviewed. These guidelines had also been disseminated to hospitals. In reviewing the guides, the Committee was concerned that there may be undue duplication if all of the guideline requirements were met, but it was noted that all required information relating to patient care should appear somewhere in the record. The main concern was that there be sufficient information in the chart, as opposed to documentation. A problem the PRO has been experiencing in this regard is that often records supplied by the hospital are illegible because of copying difficulties or there were omissions. However, no one could argue with the need for appropriate documentation and full description with information appropriate to care.

As an overview, PRO representatives reported that actual case review has diminished and the PRO's work has emphasized educational efforts. Its focus has been to conduct a pattern analysis to determine what modes of care were effective and which ones were not, and then to use this information to advise providers and, hopefully, enhance care.

With regard to claims review, fewer than 5% of all claims are considered, and these are chosen on a computer-generated, random basis. Review may also be conducted at the request of the hospital; for example, if the facility feels a patient should be discharged but the admitting physician disagrees. Reviews are also directed toward violations of hospital "dumping" and inappropriate transfer of patients.

With regard to confidentiality, the PRO has keen concerns, as well as federal directions, to maintain confidentiality. The PRO may not divulge any patient-specific information. This provides some difficulty when discussing cases. The PRO is also concerned that physicians maintain the same confidentiality in discussing their cases with review committees and peers, and the PRO Advisory Committee would urge all members to be attentive to these concerns.

James M. Bowles, MD, who has chaired this Committee since its first appointment, regrettably resigned this year. The Committee would like to thank him for his diligent and helpful efforts. Although he will be missed as Chair, he has agreed to continue service on the Committee.

William H. Mitchell, MD
Chair

Report of the Young Physicians Steering Committee

The Young Physicians Steering Committee held two meetings this year, with a third one scheduled prior to KMA's Annual Meeting. The purpose of our Committee is to discuss ways to identify and address issues of interest to young physicians and increase young physicians' involvement in organized medicine.

Our Committee works in conjunction with the AMA Young Physicians Section which was formed in 1987 to provide young physicians a direct voice in policy decision making in all levels of organized medicine. Kentucky sends a YPS Delegate to the Annual and Interim Meetings of the AMA House of Delegates. We have found it very helpful and enlightening to participate directly in establishing policies that will affect our careers.

A special young physicians' luncheon was held again last year. We were pleased to have Joy Maxey, MD, Atlanta, Immediate Past Chair of the AMA-YPS, as our speaker. We are planning to hold this luncheon again this year at noon on September 20 in the Keeneland Suite of the Hyatt Regency Louisville. Any young physician member of KMA is welcome to attend. The Committee would like to acknowledge, with appreciation, the generous sponsorship of the luncheon by the Kentucky Medical Insurance Company.

Our Committee applauds the success of the AMA in repealing the inequitable Medicare payment cuts for "new physicians." That was a welcome and appreciated victory on behalf of young members of organized medicine.

This year, we will again use special ribbons to identify young physicians attending the KMA Annual Meeting. The AMA defines young physicians as being under the age of 40 or in the first five years of professional practice.

The Committee appreciates the continuing support of the KMA Board of Trustees and the officers of the Association.

Ford Threlkheld, MD
Chair

Report of the Resident Physicians Section

The KMA Resident Physicians Section has been very active at the state and national levels during the past year. The Governing Council, made up of representatives from the four residency programs in the state, met four times this year and has had strong representation at the KMA Annual Meeting as well as the AMA Interim and Annual Meetings.

The Council's first meeting was held immediately following the joint MSS and RPS Annual Meeting on September 28 which featured an outstanding panel discussion dealing with the changes facing medicine in the legislative arena, financing a medical career, specialty choices, and managed competition. The Section was again successful in having a Resolution adopted by the 1993 KMA House of Delegates and continues to address national issues through Resolutions at the AMA-RPS meetings.

The KMA-RPS was fortunate this year to host AMA Executive Vice President James S. Todd, MD, on October 26. Doctor Todd addressed almost 250 residents at UK and UL on AMA's role in national health system reform proposals. In addition to Doctor Todd, KMA President Ardis Hoven, MD, and KMA-RPS President Judy Linger, MD, who is also a member of the AMA-RPS Governing Council, participated on the programs. We acknowledge the support of the AMA-RPS and the Upjohn Company for sponsoring Doctor Todd's visit to Kentucky.

New officers of the Council were elected in February and a special Resolution was presented at that time to outgoing President Baretta R. Casey, MD, recognizing her efforts throughout her training years on behalf of organized medicine.

On April 21, the Council heard an informative report by KMA Director of Public Affairs Don Chasteen on the actions of the 1994 Kentucky General Assembly. Of particular interest were the provisions of HB 250 pertaining to medical education. The Council will work with KMA staff in monitoring the regulations implementing these provisions.

The RPS meeting on July 21 featured a presentation by Burns Brady, MD, Chair of KMA's Impaired Physicians Committee, as well as discussion on Resolutions and other activity for the 1994 KMA Annual Meeting. The Council is pleased to cosponsor the third MSS and RPS Annual Meeting on September 20 in Louisville. With the theme, "The Art of Medicine: Evolution of Thought," the program will feature speakers from the AMA student and resident sections; KMA President Robert R. Goodin, MD; Ronald Waldridge, MD, KMA Trustee, Seventh District; and David Meacham, Cabinet for Human Resources.

Kentucky was well represented at the AMA-RPS meetings held in December and June and we would like to acknowledge and express appreciation to KMA and the residency programs at UK, UL, St. Elizabeth's, and Trover Clinic for their support of residents to attend these meetings.

In late June, KMA again participated in the Housestaff Orientations at UK and UL. Doctor Linger represented the AMA and KMA at the June 27 program at UK and KMA Fifth District Trustee Joseph Kutz, MD, addressed the new residents at UL on June 30. We are grateful to the speakers as well as to the residency programs for the opportunity to encourage residents to get involved in organized medicine.

As President, I appreciate the opportunity to represent the Section at meetings of the KMA Board of Trustees and, on behalf of the Council, want to thank the House of Delegates and individual members of KMA for their continued support.

Judy M. Linger, MD
President

Report of the Medical Student Section

The KMA Medical Student Section has been involved in activities at all levels of the federation this year with strong representation at KMA and AMA meetings. The third annual statewide meeting of Kentucky residents and students held September 28 was very successful with more than 100 in attendance to hear panelists deal with the "Changing Dimensions of Medicine."

Presidents of the MSS chapters at the University of Louisville and University of Kentucky received Outreach Program Awards at the 1993 AMA Interim Meeting in New Orleans for their recruitment of medical students to the AMA. In addition, more than 20 Kentucky medical students were in attendance at the 1994 AMA-MSS Annual Meeting and many presented testimony on a number of Resolutions and reports.

The KMA — MSS Governing Council, composed of representatives from both medical schools, met informally on March 26, to discuss goals and plans for the Section. Although a quorum was not present, the group discussed ways chapter officers could get more involved in developing membership at the two schools and work together more effectively as a state Section. Our goal in the coming year is to reactivate the state Governing Council and schedule regular meetings between the two schools so that we may have a greater influence at national meetings in regard to Resolutions and/or officers proposed by the KMA-MSS.

Recruitment efforts for 1995 membership are already underway at the two schools with letter-writing campaigns and Orientation programs. We are grateful for the opportunity that KMA affords students to participate on a number of Association committees, including last year's Reference Committees, and appreciate the continued support of student activities.

Michael Dragan, UK President
Charles Thornbury, Jr, UL President

END OF CONSENT CALENDAR ITEMS

Report of the Committee to Investigate Changing Trends in Medicine

The Committee to Investigate Changing Trends in Medicine met on April 29. The Committee's mission is to study and report on evolving delivery and payment mechanisms; to study and report on demographic trends affecting medical practice; to study and report on ethical questions regarding financial considerations versus quality of life; to investigate trends in cost containment activities; and to determine, to the extent feasible, the role of organized medicine in this changing environment.

The focus of our meeting was the wide range of activities now underway to measure the quality and appropriateness of services provided patients, particularly in the current reform activities.

HB 250, enacted by the Kentucky General Assembly, calls for a Health Policy Board to "collect, analyze, and disseminate information on the cost, quality, and outcomes of health services." The Board is to also "make an annual report on health care charges and quality, including comparisons for each hospital and ambulatory facility in Kentucky." Finally, the Board, "through the various professional licensure boards is required to develop, update, and implement parameters for clinical practice for use by health care providers."

Several national reform plans call for regional agencies to issue "report cards" rating the care of competing health plans. Some experts believe that national practice guidelines, a national data system, and a strong federal role in quality measurement will be a part of any national reform legislation that is enacted by Congress. The reason is that 50 sets of standards and performance measures would be unmanageable for multistate employers and providers and for patients that cross state lines for care. This activity is apparently underway based on the belief of those in government that more information will result in better patient care at lower cost and that Washington can devise the appropriate measurement system.

It seems that everybody has suddenly gotten into the "quality of health" business. Performance measurement, outcomes assessment, total quality management, and constant quality improvement are all terms we hear every day; but what do these terms really mean? Quality almost defies description, but most people know it when they experience it, or at least think they do.

As the reform movement matures, there is an expectation that physicians, health care plans, and other organizations will compete on the basis of both cost and quality. There is a fundamental assumption that we know what quality is and how to measure, monitor, and ensure it.

Guidelines are being formulated to evaluate patient care as we try to measure the appropriateness of medical interventions. Hundreds of millions of dollars are being spent, yet it seems we've not asked ourselves whether the tools we have are valid, worth the investment, and ready for national implementation.

Our Committee reviewed a considerable amount of the current literature available on this issue, and had the added benefit of meeting with William F. Jessee, MD, Vice President for Performance Measures and Research for the Joint Commission on Accreditation of Healthcare Organizations and Chairman of the Board of Trustees on the Commission on Professional and Hospital Activities. This report is based on our meeting with Doctor Jessee and information found in the current literature.

Evaluation of physician competence has traditionally been defined by the medical profession through standardized tests and board certification examinations. The pursuit of quality in medicine can be traced to the enactment of medical licensure laws in the 1870s and 80s. The growth of medical science during that time laid the groundwork for a professional consensus based on scientific fact which society endorsed by limiting, through licensure, those permitted to provide medical treatment. In 1910, Abraham Flexner published "Bulletin Number Four" which exposed inferior educational institutions and began a standardization process for US medical schools based on proven scientific data. This process was strengthened by the initiation of the hospital internship program, which in 1923 grew to accommodate all US medical school graduates, and later by the development of residency and specialty board certification programs.

Quality today remains in the abstract. It is subjective and largely governed by one's perspective; yet almost every health reform plan has the goal of increasing quality and decreasing cost. There seems to be a consensus among politicians that system reform can be accomplished without affecting quality. Critics of the current system say that fee-for-service medicine encourages overutilization. The evolving structure seeks to shift the financial risk of patient care to providers through capitated payments, risk withholds, and other mechanisms. Critics of that approach fear the incentives will lead to withholding necessary care. Thus it is imperative that the profession play a major role in the development of measures that will determine the appropriate degree of care given the patient.

The determination of appropriate caregivers is an ongoing quality issue. Today, just as in the days prior to the Flexner report, there are those who claim to have the knowledge and expertise to provide medical services but rely more on legislative persuasion than academic and scientific evidence to expand their scope of practice. As payors seek to tighten the dollars available to the health care system, these nonphysicians will likely seek to enhance their circumstance by claiming they can provide the same services for less money and will be willing to practice in underserved areas of the state to boot. It will be important to determine scientifically whether or not those claims can be substantiated.

Quality is also quickly becoming a marketing issue. Kentucky's reform plan will require the Health Policy Board to produce an annual report on health care charges and quality, including comparisons for each hospital and ambulatory facility in Kentucky. Most national reform plans call for some kind of "report card" rating the care of competing health plans. There is no doubt that individual physicians will be called upon to document their level of competence to a wider audience in the future. The very concept of competition is based on exclusivity. Competitors offering the best results at the best price will do well . . . others will see their patient base decline. Physicians, not marketing specialists, need to establish or at least influence, the criteria being developed in that regard.

The Committee reviewed several approaches to the development of quality standards and the following is a brief overview of a sample of the current activity.

Joint Commission on the Accreditation of Healthcare Organizations

The Joint Commission is developing standards for evaluating health care provider networks for review by an expert panel of consumers, payors, purchasers, and health care providers. A health care provider network is defined as an organized health care delivery system that provides an integrated range of services, often to an identified group of patients. The standards will address issues of network-wide integration, coordination, and accountability, and will cover such areas as patient rights, organizational ethics, continuum of care, education, communication, network leadership, utilization management, human resources management, financial management, information management, and performance improvement.

The National Committee for Quality Assurance

NCQA was established in 1979 by the Group Health Association of America and the American Association of Foundations for Medical Care (now the American Managed Care and Review Association), the trade associations for health maintenance organizations. The NCQA reviews organizations that deliver managed care services including traditional staff and group model HMOs, network and independent practice association model HMOs, mixed models, and open-ended or point-of-service products. Its goals are to improve quality and provide quality information to purchasers of managed care products.

Perhaps its most ambitious undertaking was the development of HEDIS 2.0 (Health Plan Employer Data and Information Set), a compilation of over 60 standardized health plan performance measures which was developed by both health plan representatives and purchasers. HEDIS 2.0 is designed to enable health plans to standardize how they specify, calculate, and report information; specifically, quality, enrollee satisfaction, utilization, and financial data. HEDIS 2.0 will make health plan data available for the percentages of Pap smears, pediatric immunizations, disenrollment ratios, vaginal vs c-section delivery occurrences, and other performance measures.

The document was reportedly developed to help employers understand the value of the plan purchased for employees and how to hold a health plan "accountable" for its performance. By the end of 1993, NCQA planned to have reviewed the quality of more than one-third of the nation's 550 managed care organizations.

Group Health Association of America
The GHAA, an association representing HMOs and large for-profit insurers, is proposing a set of national standards for HMOs. Currently, HMOs are subject to regulation which varies from state to state. The proposal includes standards for:

Health Delivery Systems. — Systems must be organized and provide services through participating providers, and providers must agree to accept a predetermined payment. Plans must not discriminate, must establish policies to ensure accessibility, must promote appropriate patient care, permit choice and change of a personal physician from participating primary care physicians, and ensure that participating providers and facilities are appropriately licensed, certified, or accredited.

Quality Assurance Systems. — Plans must administer an internal quality assurance and quality improvement program that is clearly identified and explained to all participants, communicates findings to providers and consumers with a goal of improving health care outcomes, measures impact of findings on care delivered by providers, collects and analyzes data for improvement strategies, incorporates a credentialing process, or is accredited by an independent organization that conducts objective quality reviews based on comparable data.

Confidentiality. — Plans must establish, maintain, and periodically review procedures to protect the confidentiality of patient information.

Other standards include market conduct requirements, administrative standards, enhanced capitalization standards, financial guarantees by owners or controllers of plans, protection of consumers in the event of insolvency, guaranty funds, and the preemption of state laws such as mandated benefit and any willing provider laws.

The National Association of Insurance Commissioners
The NAIC is comprised of the insurance commissioners of each state. It often develops model legislation for consideration by state legislatures. Currently most insurance laws are based on insurance company structure models. In addition, there is variance among the states as to what offices have jurisdiction over insurance companies and health care plans. This has resulted in some plan hybrids developing that have fallen through the regulatory cracks.

The NAIC is working on draft model state legislation that will address noninsurance company health plans in the following areas:
— Investigate unfair trade/claims practices
— Require ongoing and periodic operations and compliance audits utilizing appropriate financial and performance measures
— Establish fair and unbiased process for consumer complaints
— Guarantee access to care for individual consumers
— Assure compliance with standard benefit requirements and supplemental benefit package standards
— Establish mechanisms to detect and investigate fraud
— Monitor financial condition of health plans and resolve any financial impairment
— Obtain and protect data on claims, services, plan performance, and health policy
— License only fiscally sound plans with competent management, adequate resources, and sufficient provider capacity
— Institute measures to assure that agents are appropriately licensed

In addition, NAIC has recommended to Congress that any federal health care reform provide state insurance departments with the authority to regulate the solvency of all risk-bearing health care plans. Such authority would extend to those entities currently exempt from state insurance department regulation under ERISA (self-insured plans).

National Association of Managed Care Regulators
This group represents State Department of Health regulators and is developing both model state statutes and regulations regarding contracts between managed care organizations and providers of health care services. The purpose of this model is to assure availability, accessibility, and quality of health care services provided by managed care organizations by establishing requirements for written agreements with participating providers regarding standards, terms, and provisions under which the provider will provide services and/or supplies to covered persons and the compensation to participating providers for those services and/or supplies.

Healthcare Management Guidelines
This is an example of medical guidelines developed by a private actuarial firm, Milliman and Robertson, Inc. They are widely used by such companies as Cigna, Metropolitan, US Health Care, Kaiser Permanente, and several state Blue Cross/Blue Shield plans. The guidelines focus on shortened lengths of stay and have generated controversy in areas where they have been implemented. While widely used, critics raise a number of questions about their practical implementation. Examples of lengths of stay suggested by the guidelines are two days for an above-the-knee amputation; one day for an open cholecystectomy, appendectomy, or diabetic ketoacidosis; two days for a cesarean section; and 12 hours following a vaginal delivery.

Practice Guidelines
Many medical specialty societies, as well as the AMA, are working to develop useful practice parameters and about 1500 are in use today. Practice guidelines are a response to the perception that variations in practice between physicians were great enough to warrant guideline development, that some of the high cost of medical care could be explained by inappropriate care, and that standards were needed to bring outliers into compliance. One explanation for variations in practice was the lack of information on patient outcomes. That led to the establishment of the Agency for Health Care Policy and Research which focuses on the outcome of medical interventions and the development of guidelines.

Considerable effort has gone into guideline development and a significant amount of money is being spent. It has been reported that one practice parameter took two years to develop and cost well over one million dollars. Estimates for quality initiatives offered by the Clinton administration range from $250 million per year (administration figures) to $1.6 billion per year (AMA figures).

Guidelines are being established to reduce variations in practice; direct the allocation of resources; guide consumer purchasing decisions in health insurance; certify and license physicians, hospitals, and health care organizations; help make decisions about which health services to fund; and assess medical liability claims.

United Health Care Corporation: A Report Card on Health Care
United Health Care Corporation is a large HMO with a concentration on the east coast. It was one of the first private HMOs to develop four categories of performance measures that can be used to evaluate health care delivery systems and services. Other large managed care organizations producing "report cards" include the Group Health Cooperative of Puget Sound, Rush Prudential Health Plans of Chicago, Kaiser Permanente, and US Health Card. The goal is to provide specific measurements that are valid but easily understood. The results are then compiled into a "report card" that allows purchasers to evaluate or compare a given health care system. The report card is reportedly designed to cover the spectrum of health care delivery in terms that are important to purchasers to allow them to hold delivery systems accountable for the health care provided.

The report card emphasizes customer satisfaction, appropriate access to services that can maintain and improve health status, efficient performance so costs paid by purchasers can be maximally allocated to health care services and not to administrative expenses, and giving customers coverage at an affordable and predictable price.

The plan routinely surveys plan members to gauge their degree of satisfaction with the plan. It measures perceptions of quality, the manner in which the customer service department responds to members, and the level of member satisfaction with access to the plan and with the selection of physicians from which they can choose. Overall satisfaction is measured to show how members perceive their health plan when taking all factors into consideration.

United Health Care believes that how a health care delivery system provides patient care for certain medical conditions and procedures can be a key indicator as to the appropriateness and effectiveness of that care. The following are the quality indicators it uses:

Preventive Services
— The percentage of pediatric immunizations given the covered population
— The percentage of covered females over 50 years of age given annual mammographies
— The percentage of covered females receiving annual Pap smears

— The percentage of annual eye exams given diabetic patients

Other areas measured include neonatal outcome/low birth weight, organ transplant survival rates, the percentage of cesarean sections performed, and monitoring and early treatment of pediatric asthma.

Operating efficiency and administrative costs are reported in terms of cost per member per month. (There are no comparative data so it is difficult to determine the usefulness of this information.) The plan measures claims processing on the speed, accuracy, and thoroughness of the system. The plan also compares its rate of premium increases against other indicators, its utilization of hospital days per 1000 members, hospital admissions per 1000, and average length of hospital stay.

Standardized Patients

State licensure boards are under increasing pressure to demonstrate they can identify, re-educate, and when appropriate, delicense incompetent physicians. The Federation of State Medical Licensure Boards is laying the groundwork for regional evaluation centers, to which physicians suspected of substandard care could be referred for a battery of tests, including encounters with standardized patients. The "standardized patient" is a new approach to allow medical licensure boards to assess the clinical competence of physicians. In this scenario, a physician examines a symptomatic patient and takes a medical history. The trained patient and/or observers critique the physician's technique and the resulting diagnosis. Those whose clinical skills are identified as lacking would be referred to retraining programs tailored to their specific needs. The first such center, operated by the Federation of State Medical Licensure Boards and the National Board of Medical Examiners, could accept its first referrals by early next year, and both Massachusetts and New York are moving ahead with similar programs.

Currently, most cases before licensure boards are for substance abuse, illegal prescribing, or other criminal activity. FSMLB officials estimate that competency issues comprise only 25% of the Boards' disciplinary actions. The standardized patient approach measures a physician's ability to reason through a case and interact with a patient, skills currently not tested in the licensure examination process. Canada has been using a similar postlicensure assessment model since 1986 with reported positive results.

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While some may question the usefulness of these various approaches to quality measurement and reporting, they are a response to demands by payors for greater accountability from providers. The question, still unanswered, is whether or not the data truly are useful measurements of quality.

When all is said and done, patients will be the final judge of quality, or perhaps more accurately, of the value they receive from their plan and physician. This is an important distinction. Many times physicians think in terms of quality relating to the physicians' level of training, certification, and specialty, the availability of diagnostic assistance and state of the art technology. Patients, on the other hand, may be more impressed not only by the provider's technical skills, but his/her personal manner, explanations of care, time spent during the visit, the appointment wait, convenience of the office location, telephone access, and their perception of the results of their encounter with the physician. Was the result of their encounter with a physician valuable to them relative to the money spent?

A study reported by Rubin, et al, in the August 1993 issue of *JAMA* sought to determine how patients in different types of practice, solo or single specialty, multispecialty group or HMO — and with fee-for-service or prepaid physician payment arrangements — evaluate their medical care, based on the above parameters. Patients of solo practitioners were more likely (64%) to rate their visit excellent than those of multispecialty groups (48%) or HMOs (49%). Patients of solo practitioners rated all aspects of care better than HMO patients did, most markedly appointment waits (64% vs 40% excellent) and telephone access (64% vs 33% excellent). Of the five practice types and payment method combinations, solo fee-for-service patients rated their visits best and HMO patients worst. Care was rated better in small rather than large practices regardless of fee-for-service or prepaid. Physicians with visit ratings in the lowest 20% were nearly four times as likely to lose patients within six months than physicians in the highest 20%.

We seem to be moving from a system which relies on the experience, intelligence, and careful decision making by individual physicians to one of codifying the practice of medicine; but many questions remain unanswered, not the least of which is a useful definition of quality. Will guidelines change physician behavior? Will quality improve? Will money really be saved or merely transferred from one cost center to another? Is all the effort going into guidelines worth it and how will we ever know for sure?

What organization should have the final say when guidelines conflict? For example, the National Cancer Institute recently stopped recommending mammographies for women under 50, but the American Cancer Society still recommends the test for females over 40.

Are these approaches to quality assurance and cost containment useful tools or are they the latest trendy buzz words pushed by government and business interested in reducing costs? And what do patients think about all this?

Today, society seems caught up in a need for instant results. If someone has a notion that can be sold to politicians and other policymakers, we go full speed ahead to implementation before we make an effort to see if it will work. Certainly "quality" is important and we all want to provide and receive it; but its measurement, like the technique for shoving a cloud into a bottle, hasn't been perfected yet.

It is important for each of us to remain vigilant as all the interested parties grapple with the "quality" dilemma and to use our influence to enhance what is useful and discard that which is not.

As Chair of the Committee, I appreciate the continued interest and participation of the Committee members.

Marjorie R. Fitzgerald, MD
Chair

Recommendations, Reference Committee 4:
The Reference Committee reviewed the information provided in this excellent report and recommends that this information be disseminated to the general membership through KMA publications.

During discussion of this report, special mention was made regarding clarification to the Health Policy Board and third-party payors that practice guidelines are **not** standards of care, nor or they intended to be definitions of "reasonable treatments."

The Committee would like to thank the Chair, Dr Marjorie Fitzgerald, and the Committee to Investigate Changing Trends in Medicine for this report, and recommends that it be adopted.

Report of the Physician Organization Study Committee

The Physician Organization Study Committee was formed after the adoption of Resolution B by the 1993 Kentucky Medical Association House of Delegates. Resolution B called for the Kentucky Medical Association to:

1. Initiate a study of the feasibility of establishing a physician-owned and directed economic entity which allows all KMA members the opportunity to participate in delivery and payment systems evolving from health system reform measures;
2. Consider legal, professional, and financial requirements of establishing a physician-owned and directed economic entity, as well as the corporate structure, philosophy, and future relationships with KMA and affiliated organizations;
3. Engage the services of appropriate consultants, as required, to help determine the advisability of such an organization, as well as levels of professional and financial support deemed necessary to assure fiscal viability.

An 11-member Committee was appointed by the Board of Trustees to serve, and due to the rapidly changing health care environment, the Committee decided to meet in quick order to determine its focus. The Committee first met on December 15, 1993, and adopted a mission statement summarizing the contents of Resolution B (1993). Also discussed was a summary of similar activities in other states. Among states reviewed which are currently studying the feasibility of forming some type of physician-owned and/or directed managed care organization or which have one in existence were Arkansas, California, Connecticut, Florida, Michigan, New Mexico, New York, North Carolina, Oregon, Pennsylvania, South Carolina, South Dakota, Texas, and Vermont.

At the December meeting, the Committee also discussed many of the managed care activities currently underway across Kentucky. Some of these activities were initiated by insurance carriers, some by hospitals, and yet others by physicians. Several of these existing and operational managed care entities expressed an interest in meeting with the Committee; however, it was the consensus of the Committee that any such meetings would not

be productive until there was clearer direction as to what KMA's objectives were in forming a physician-directed organization. Additionally, the Committee agreed that a number of policy issues needed to be prioritized by not only the Committee, but by the KMA Board of Trustees as well. As a result, a joint meeting of the Committee and the Board of Trustees was held on March 3, 1994, at which professional expeditors/facilitators were utilized to help establish and prioritize the goals and objectives of the Committee.

Bruce Balfe and Nancy Bannon of the AMA served as facilitators for this meeting. Mr Balfe related what was taking place in the managed care arena around the country and attempted to help the group determine what would be feasible in Kentucky.

In discussion, several assumptions were made:

1. The industry is aggregating, both on the buyer side and the seller side.
2. The aggregation phenomenon is primarily market-driven. Legislative efforts, both national and state, are merely catalyzing the process.
3. The current form that the aggregation process is taking is being called managed care.
4. The likelihood is that the form will change over time, but the basic aggregation process will continue.
5. KMA's role should be to help members cope with, and even thrive in, the new environment.

In discussing managed care in Kentucky, it was noted that the status is quite varied by region, and in most cases, not as mature as in some other states.

The Board and Committee members identified the related needs of physicians and the strengths and weaknesses of KMA that affect its potential role in the managed care field. The needs were classified into several different categories: information, advice, advocacy, materials, and access to power in the market. A list of 23 characteristics (such as access to and credibility with physicians, access to capital, relationships with hospitals, etc) were identified and classified as either a strength or a weakness/constraint.

General options available to KMA in responding to the managed care phenomenon were outlined, and the major approaches identified were:

1. Provide various kinds of support services to members to help them deal with managed care.
2. Position KMA to be a direct player in the managed care market.
3. A combination of 1 and 2.

It was noted that a support role could take a number of forms, ranging from providing information, engaging in negotiations on behalf of physicians, contract evaluation, a "watchdog" role, administrative support, and endorsing or certifying managed care plans. It was related that a number of state medical associations have chosen this route because they felt they could not be successful as a direct player in the market.

At the conclusion of the consensus-building exercise, it was agreed that the Committee should continue to study both economic and noneconomic models that would assist members as they deal with the anticipated changes brought about by health system reform.

The Physician Organization Study Committee was asked to begin to utilize local advisors with experience in managed care organizations. It was noted that KMA Legal Counsel has background in this area and would be a pertinent source.

The Committee next met on April 13, 1994. Charles J. "Mike" Cronan, IV, KMA's outside legal counsel, was in attendance and discussed the factors which should be considered and the appropriate role for KMA in dealing with managed care. He noted the two most important areas to be considered are market and philosophy, and he discussed both at length with the Committee.

At the conclusion of the April meeting, the Committee recommended its future plans of action, both short-term and long-term, to the Board of Trustees, which were approved as follows:

1. Publicize AMA's Doctors Resource Service (DRS), which was designed by AMA specifically for physicians involved or considering involvement in managed care.
2. Make Committee members and staff available to speak to interested groups of physician members across the state. Staff could develop the text and some accompanying slides. (It should be noted that a presentation has been developed and presented to various physician groups throughout the state.)
3. Begin research on the status of managed care, physician organizations, and nonphysician organizations in Kentucky. There is no central source of information readily available currently.
4. Influence the market in Kentucky by helping to influence the structure that is negotiated by recommending physician-friendly firms (legal, financial, business, actuarial consultants) to perform certain services. KMA can serve as a central reference point to put doctors together with competent advisors.
5. Sponsor managed care seminars on a statewide, regional, or local basis using consultants interviewed and "endorsed" by KMA.

Two of these seminars were held in Richmond and Louisville in mid-July. They were well attended and provided many Kentucky physicians with needed information regarding managed care. It is hoped that a third seminar can be scheduled in the western area of the state later this fall.

Among the long-term goals agreed to by the Committee were:

1. Explore ongoing educational activities, to include quality assurance and outcomes measurement; development and ongoing refinement of practice parameters, utilization review, and appropriate CME opportunities.
2. Explore arrangements which might offer some benefits of a physician organization without the financial commitments required by some types of physician organizations (ie, partnerships, joint ventures).

The Committee has not recommended that KMA develop an insurance-based entity in Kentucky based upon a variety of reasons. You may recall that Resolution B was written in anticipation of reforms generated by state and federal legislation. Last July, President Clinton had not released his health reform plan. He did not make it public until late September of 1993. During the summer of 1993, there was much speculation in the press and from AMA that the plan would call for health care alliances that would contract with large groups of providers which would form accountable health plans.

In the summer of 1993, KMA had just completed a special legislative session on reform where a central tenet of the reform plan was the establishment of two large purchasing alliances which would contract with groups of providers for medical services. If these alliances came into existence, physicians would need some type of structure that would allow them to become an accountable health plan, as envisioned in these reform schemes.

Now, many believe the alliance concept to be unacceptable at the national level, and the state's version of an alliance has changed drastically since first introduced.

In addition, other developments have surfaced which were unknown at the time the Resolution was developed. Some physician-sponsored physicians' organizations have been developed since last year. There is more activity in the areas of local physician-sponsored organizations than originally known.

The challenge of setting up an insurance-based physician organization is formidable. They are expensive to establish. No matter how much physician support is given these entities, they will still have the general characteristics of insurance companies. They will need to market their product to the buyers, requiring sales representatives and other marketing assistance. They will need a way to collect and distribute money, requiring administrative assistance, computers, and management personnel. They will need a way to judge that the premiums paid will be enough to meet their financial obligations, which means hiring actuaries and building reserves in addition to generating enough funding to cover initial startup costs.

The Committee continues to study and explore methods to meet the charge of Resolution B (1993). There is a window of opportunity for Kentucky physicians to have some control over their futures in a managed care environment. Keep in mind that only physicians are licensed to practice medicine and, therefore, they will be a major player in the emerging health care delivery system. The Committee will continue its efforts to help KMA develop the best available means to meet this goal.

As Chair, I appreciate the active participation of the members of the Committee and their commitment to the Committee's goals and responsibilities.

Robert R. Goodin, MD
Chair

Recommendations, Reference Committee 4:
The Reference Committee reviewed the report of the Physician Organization Study Committee which was formed in response to Resolution B from the

1993 House of Delegates. It is recommended that all Delegates read this excellent report from Dr Robert Goodin and his Committee, and note its recommendations are that the KMA not form an independent health care entity at this time.

Reference Committee No. 4 recommends that this report be adopted.

RESOLUTION C

Impairment Prevention and Education in the Training Years
KMA Resident Physicians Section

WHEREAS, the American Medical Association has a long-standing policy supporting the teaching of the prevention of physician impairment to medical students and residents; and

WHEREAS, the Kentucky Medical Association, through its Impaired Physicians Committee, has been recognized nationally for its successful intervention program, and now through the Kentucky Physicians Health Foundation continues that work; and

WHEREAS, it is generally recognized that many of the problems with substance abuse begin to surface in medical school and early in the training years of physicians; now, therefore, be it

RESOLVED, that KMA support and encourage formal training for students and residents on substance abuse and impairment in Kentucky's medical schools and residency programs; and be it further

RESOLVED, that medical schools and residency programs be made aware of the services of the Kentucky Physicians Health Foundation to assist in developing such training opportunities.

Recommendations, Reference Committee 4:
Reference Committee No. 4 reviewed Resolution C introduced by the Resident Physician Section. Positive testimony was heard from the President of KMA/RPS, members of the Board of Trustees, and the Committee for Impaired Physicians. Reference Committee No. 4 recommends the adoption of Resolution C.

RESOLUTION N

Primary Care During Perinatal Period
Fayette County Medical Society

WHEREAS, obstetricians take care of their pregnant patients' primary medical problems such as "common colds," blood pressure management, etc, in addition to prenatal care, delivery, and postpartum care; and

WHEREAS, the American College of Obstetricians and Gynecologists considers obstetricians primary care physicians; and

WHEREAS, already one major HMO in Kentucky (Healthwise) accepts obstetricians as primary care physicians during the pregnancy period; and

WHEREAS, classification as a specialist results in undue delay in referral of obstetrical patients through the primary care physician gatekeeper to another physician; now, therefore, be it

RESOLVED, that obstetricians be regarded as primary care physicians to their obstetrical patients during the perinatal period, only, and that the Kentucky Medical Association advise insurance companies operating in Kentucky of this position.

Recommendations, Reference Committee 4:
Reference Committee No. 4 reviewed Resolution N and recommends that it be adopted with the following amendment which deletes the last phrase of the "Resolved" so that it now reads:

RESOLVED, that the obstetricians be regarded as primary care physicians to their obstetrical patients during the perinatal period./ ~~**only/ and that the Kentucky Medical Association advise insurance companies operating in Kentucky/ of this position/**~~

The motion was seconded from the floor. Magdalene Karon, MD, Delegate from the Fayette County Medical Society, was recognized, and made a motion to amend the Reference Committee action by addition of a second Resolved, to read:

RESOLVED, that the Kentucky Medical Association so inform the Kentucky Insurance Commissioner, all third-party payors in the Commonwealth of Kentucky, and the Kentucky Health Policy Board.

The motion was seconded from the floor and carried. Resolution N, adopted as amended by the Reference Committee and House, reads as follows:

RESOLUTION N
(Adopted as amended)

Primary Care During Perinatal Period
Fayette County Medical Society

WHEREAS, obstetricians take care of their pregnant patients' primary medical problems such as "common colds," blood pressure management, etc, in addition to prenatal care, delivery, and postpartum care; and

WHEREAS, the American College of Obstetricians and Gynecologists considers obstetricians primary care physicians; and

WHEREAS, already one major HMO in Kentucky (Healthwise) accepts obstetricians as primary care physicians during the pregnancy period; and

WHEREAS, classification as a specialist results in undue delay in referral of obstetrical patients through the primary care physician gatekeeper to another physician; now, therefore, be it

RESOLVED, that obstetricians be regarded as primary care physicians to their obstetrical patients during the perinatal period, and be it further

RESOLVED, that the Kentucky Medical Association so inform the Kentucky Insurance Commissioner, all third-party payors in the Commonwealth of Kentucky, and the Kentucky Health Policy Board.

RESOLUTION R

Ophthalmologists as Primary Eyecare Providers
Fayette County Medical Society

WHEREAS, ophthalmologists provide primary, secondary, and tertiary *eyecare*; and

WHEREAS, optometrists have declared themselves to be primary and secondary *eyecare* providers; and

WHEREAS, the Kentucky General Assembly has mandated that optometrists can provide diagnostic and therapeutic treatment for the citizens of Kentucky; and

WHEREAS, the American Academy of Ophthalmology recognizes ophthalmologists as comprehensive eyecare providers; and

WHEREAS, many health maintenance organizations and preferred provider organizations are using optometrists as the primary and secondary eyecare providers; and

WHEREAS, inappropriate delay in referral of potentially blinding ocular disorders increases morbidity and cost to the citizens of the Commonwealth of Kentucky; now, therefore, be it

RESOLVED, that ophthalmologists be regarded as primary *eyecare* providers; and be it further

RESOLVED, that the KMA so inform the Kentucky Insurance Commissioner, all third-party payors in the Commonwealth of Kentucky, and the New Kentucky Health Policy Board.

Recommendations, Reference Committee 4:
Reference Committee No. 4 had long and extensive discussions with representatives of the Fayette County Medical Society, the American Academy of Ophthalmology, and the Board of Trustees regarding Resolution R.

Reference Committee No. 4 recommends that Resolution R be amended through deletion and addition as follows:

RESOLVED, that ophthalmologists be regarded as *comprehensive (primary, secondary, and tertiary)* ~~**primary**~~ **eyecare providers; and be it further**

RESOLVED, that the KMA so inform the Kentucky Insurance Commissioner, all third-party payors in the Commonwealth of Kentucky, and the new Kentucky Health Policy Board.

Reference Committee No. 4 recommends that Resolution R be adopted as amended.

RESOLUTION S

Use of Laser Therapy
Fayette County Medical Society

WHEREAS, lasers are defined as being invasive and surgical; and

WHEREAS, it requires finely skilled physicians to operate the laser; and

WHEREAS, physicians are required to manage the complications of laser use; and

WHEREAS, Medicare defines use of the laser as an invasive procedure; and

WHEREAS, the state of Oklahoma has recently passed legislation allowing other health care providers to utilize laser therapy; now, therefore, be it

RESOLVED, that the KMA recognize that laser procedures are invasive to the human body; and be it further

RESOLVED, that the KMA inform the Kentucky Board of Medical Licensure and the newly formed Kentucky Health Policy Board that the use of lasers is invasive to the human body and that only physicians should be authorized to utilize laser therapy.

Recommendations, Reference Committee 4:
Reference Committee No. 4 had extended discussion on Resolution S. The Committee recommends that Resolution S be amended through deletion and addition as follows:

RESOLVED, that the KMA recognize that laser procedures are *surgical in nature* to the human body; and be it further

RESOLVED, that the KMA inform the Kentucky Board of Medical Licensure and the newly formed Kentucky Health Policy Board that the use of lasers is *a surgical procedure in nature to the human body and that only those practitioners licensed to perform surgery* should be authorized to utilize laser therapy.

Reference Committee No. 4 recommends that Resolution S be adopted as amended.

Mr Speaker, I recommend the adoption of the Report of Reference Committee No. 4 as a whole, as amended.

Mr Speaker, I want to personally thank the other members of the Reference Committee No. 4 who have attempted to assist the House of Delegates to try to formulate policies on some very worthwhile issues. Members of the Committee were: Gordon W. Air, MD, Crestview Hills; Andrea Faulconer, Louisville (MSS); William D. Medina, MD, Lexington; Donna M. Skinker, MD, Lexington (RPS); and Joseph G. Weigel, MD, Somerset. I would also like to personally thank Debbie Best for her assistance in the preparation of this report.

Respectfully Submitted,
REFERENCE COMMITTEE No. 4
G. Randolph Schrodt, Jr, MD, Louisville, Chair
Gordon W. Air, MD, Crestview Hills
Andrea Faulconer, Louisville (MSS)
William D. Medina, MD, Lexington
Donna M. Skinker, MD, Lexington (RPS)
Joseph G. Weigel, MD, Somerset

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 5

Vaughn W. Payne, MD, Louisville, Chair

38. Report of the Committee on Maternal and Child Health
39. Report of the Technical Advisory Committee on Physician Services (Title XIX)
40. Report of the Committee on Community and Rural Health
41. Report of the Committee on School Health, Physical Education, and Medical Aspects of Sports
42. Report of the Judicial Council
43. Report of the Physician-Attorney Liaison Committee

Revised Resolution E — Kentucky Organic Growers (Estill County Medical Society)
Resolution L — Regulatory Agencies (Jefferson County Medical Society)
Resolution M — Practice Environment in Kentucky (Fayette County Medical Society)
Resolution T — Discount Option Program (DOP) (Fayette County Medical Society)
Resolution V — Discount Option Program (Board of Trustees)

ITEMS FOR CONSENT
Reference Committee No. 5 reviewed the following items and recommends they be filed, by consent of the House, without discussion:

39. Report of the Technical Advisory Committee on Physician Services (Title XIX) — filed
41. Report of the Committee on School Health, Physical Education, and Medical Aspects of Sports — filed
42. Report of the Judicial Council — filed
43. Report of the Physician-Attorney Liaison Committee — filed

Reference Committee No. 5 would like to express its appreciation to the chairs and members of these committees for the nice reports about their efforts in dealing with the issues discussed in the reports.

Mr Speaker, Reference Committee No. 5 recommends adoption of the Consent Calendar as a whole.

Report of the Technical Advisory Committee on Physician Services (Title XIX)

The Technical Advisory Committee on Physician Services (Title XIX), "Physician TAC," is one of 11 provider groups represented on the Advisory Council for Medical Assistance. The Physician TAC meets as needed to discuss and evaluate problems and concerns faced by physicians when dealing with the Kentucky Medical Assistance Program (Medicaid). If the Physician TAC determines that the issues discussed require action, the Chair presents these issues in the form of a written report to the Advisory Council and makes a formal recommendation for action.

Pursuant to a formal opinion from the Cabinet for Human Resources in 1991, all technical advisory committees continue to be subject to the provisions of Kentucky open meetings laws, KRS 61.805-61.850. These laws stipulate that meetings shall be open to the public and shall be scheduled to allow effective public observation and news media coverage.

During the past year, the Physician TAC and KMA nominated physicians to serve on the Drug Formulary Advisory Board (previously functioning as the Formulary Subcommittee) and the Drug Use Advisory Board. Both of these advisory boards are mandated by federal law to serve in an advisory capacity to the Medicaid Program. Administrative orders were issued in December 1992 to formulate these advisory boards, and membership on each board includes four physicians selected from a list of nominees provided by KMA. The Formulary Board advises the Department for Medicaid Services on matters relating to the outpatient drug list, drug prior authorization process, coverage status for new drugs and other drug-related matters, and makes recommendations to the Medicaid Commissioner concerning the composition of outpatient drug lists.

Responsibilities of the DUR Board include advising the Department for Medicaid Services on matters relating to drug use therapy, making recommendations to the Medicaid Commissioner on retrospective drug use review standards, developing educational topics on common drug therapy problems and improvement in quality of drug therapy, and establishing standards for identification of suspected fraud and abuse.

During the past year, the Physician TAC met on two occasions and reviewed many concerns expressed by Kentucky physicians. The major issue discussed during the year concerned reimbursement for certain emergency room diagnoses and the utilization of triage nurses. It was the consensus of the Physician TAC that well-trained triage personnel can be a cost-effective tool to determine an emergency situation. The TAC will continue to study the issue of an authorized emergency room diagnosis list and communicate its findings to Medicaid officials.

Other matters considered by the Physician TAC during the last year include infant apnea monitoring guidelines. The TAC recommended that infant apnea monitoring continue for six months if there is a family history of sudden infant death syndrome. The TAC also reviewed case management protocol for home infusion therapy and disease-based therapeutic algorithms for selected diseases as proposed by the DUR. The Physician TAC concluded that algorithms can be utilized as an academic tool, but should not be relied upon as a clinical tool.

Several physicians' grievances concerning surgical reimbursement and billing for nonphysician practitioners were also reviewed by the Physician TAC and successfully resolved. In addition, the TAC spent a fair amount of time during the past year discussing potential Medicaid funding sources and the effect of state health care reform on the Medicaid program.

The Physician TAC will continue its efforts to provide a meaningful forum for Kentucky Physicians to present their concerns, suggestions, and ideas in order to provide quality medical services to Kentucky's indigent population.

As Chair, I would like to thank my fellow Committee members for the time and effort they expended during this past year. I would also like to thank the Medicaid staff for their assistance throughout the year.

A. O'tayo Lalude, MD
Chair

Report of the Committee on School Health, Physical Education, and Medical Aspects of Sports

The Committee on School Health, Physical Education, and Medical Aspects of Sports met on three occasions during the 1993-94 year. This Committee is a "working committee" and requires every member to be involved in some facet of the Committee's internal and external operations.

During evaluation of the 1993 Sports Medicine Symposia, Julian Tackett, ex-officio Committee member representing the Kentucky High School Athletic Association (KHSAA), expressed appreciation to Symposia chairs for their continued assistance and noted that for many years the physicians of this Committee have volunteered their time and expertise in educating high school coaches in sports safety and medicine. The following dates, with their chairs, were set for 1994 Symposia:

1. April 23, 1994 — Meadowview Regional Hospital & Charlotte Harris, MD, Maysville
2. May 14, 1994 — Ephraim McDowell Medical Center & R. Quin Bailey, MD, Danville
3. June 4, 1994 — U of L & Raymond G. Shea, MD/R. John Ellis, MD, Louisville
4. June 11, 1994 — Jewish Hospital & Ronald E. Waldridge, MD, Shelbyville
5. June 17, 1994 — Murray-Calloway County Hospital & Kathie Pierce, Murray
6. June 17, 1994 — Trover Clinic & James M. Bowles, MD/Joseph E. Roe, MD, Madisonville
7. June 18, 1994 — King's Daughters' Medical Center & Garner E. Robinson, MD, Ashland
8. June 18, 1994 — Lexington Clinic Sports Medicine & W. Ben Kibler, MD, Barbourville
9. June 25, 1994 — UK Hospital & David N. Caborn, MD, Lexington
10. July 22, 1994 — St. Elizabeth Sports Center & Michael J. Miller, MD, Highland Heights
11. July 23, 1994 — KY Sports Medicine & Mary L. Ireland, MD, Lexington (In conjunction with KAPOS)

Make Up Symposia

1. September 24 — Elizabethtown Surgical Center & William C. Nash, MD, Elizabethtown
2. October 1 — KY Sports Medicine & Mary L. Ireland, MD, Richmond

Kentucky was one of five states to experiment with a playing cast and closed cell foam padding during the 1993-94 high school football season. Committee members participated in a survey rating the forms to be completed by medical personnel and game officials when a player required a playing cast for participation. These forms, used for obtaining data, were to be tabulated at the end of the playing season by KHSAA and a permanent rule will be made. The final outcome of the survey will be considered by the Committee upon its completion.

The Committee has continued to express considerable concern about student athletes receiving proper preparticipation medical exams prior to competing in varsity athletics. The Department of Education currently requires written consent of the student's parent and physician in order to participate in interscholastic sports. KHSAA provides physical examination forms to be signed by the physician examining high school athletes; however, it is believed that many local school districts are not utilizing these forms and some students may not be receiving thorough exams. The Committee reviewed the physical examination form currently being required by KHSAA and compared the form to those used by athletic associations in states surrounding Kentucky. In an attempt to adopt a universal preparticipation exam form for high school athletes throughout the state, a subcommittee was formed to develop a more comprehensive form. Various forms were submitted for review with a form developed by Mary L. Ireland, MD, being adopted. Mr Tackett reported at the Committee's final meeting that the preparticipation exam form approved by the Committee had been endorsed by the KHSAA Board of Controls and is being mailed to all KHSAA member schools for implementation. Statewide usage of the form is expected within one year and will be the only preparticipation physical exam form furnished to schools by KHSAA in the future. KHSAA will recommend that the form be kept in the possession of the athletic director or trainer at the local high school and be taken to all athletic events in which the student participates. KMA will send the form to all actively practicing physicians in Kentucky with a cover letter explaining that the form must be completed by a licensed physician or osteopath and that a copy should be kept in the examining physician's office.

The Committee reviewed an inquiry this year regarding a Department of Education regulation permitting Advanced Registered Nurse Practitioners, Physician Assistants, and EPSDT (Early Periodic, Screening, Diagnosis, and Treatment Program) providers to perform school physical exams for 6th graders. The inquiry questioned the quality of medical care being received by many school children due to this regulation. Terry Vance, ex-officio Committee member representing the Department of Education, explained that the regulation was written under the direction of a Task Force composed of physicians, ARNPs, and PAs, with the Department assuming that all ARNPs and PAs work under the supervision of a licensed physician. She noted that the intent of the Task Force was to see that all school children receive some form of health care and that many rural children do not have easy access to a physician. After reviewing the regulation, it was determined that only the Kentucky Board of Medical Licensure can determine if a person is performing the unauthorized practice of medicine and the Committee recommended that KMA obtain the Board's opinion on this matter. The Committee recommendations were forwarded to the Board of Medical Licensure in a letter from Ardis D. Hoven, MD, KMA President.

Advance copies of the second printing of "A Syllabus of Sports Injury Care for the Kentucky High School Coach" were provided to Committee members. Copies will be provided to every high school varsity coach in Kentucky. This 76-page syllabus has been received favorably and we plan future periodic updates.

On behalf of the Committee, we appreciate the confidence of the KMA Board of Trustees and look forward to a productive year in 1994-95.

R. Quin Bailey, MD
Chair

Report of the Judicial Council

The Judicial Council has not formally met over the last year; however, it has dealt with many issues informally through telephone calls and correspondence.

A major portion of the Council's activities during the past year were directed at patient complaints and acting as arbiter on physician activities. Many of the patient complaints continue to relate to the release and/or transfer of patient records. It is the feeling of the Council that most of these ongoing medical record problems are addressed in provisions of House Bill 250 (Health Systems Reform) and House Bill 928 (Workers' Compensation Reform) and should alleviate many of the patient complaints in this area.

Another area of ongoing concern for the Council has been the issue of self-referral. This issue has also generated a good deal of attention at the state and federal levels. In fact, HB 250 adopted the Stark II provisions as law in Kentucky. These provisions will become effective in Kentucky on

January 1, 1995, and after that date physicians may not bill Medicare, Medicaid, or any individual or third-party payor for services furnished following a prohibited referral. This law should alleviate many of the Council's activities in this area.

Cases referred to the Judicial Council during the past year include a complaint about a physician dispensing medications and other products from an associated business entity located near the office. Other cases involved the appropriateness of a surgery fee and a situation where a physician informed a patient's family of an addiction problem without consent. The Council continues to investigate these cases with the help of the local Trustees.

Another issue considered by the Council concerns guidelines for medical consultants. The Council continues to work with the Kentucky Board of Medical Licensure to draft guidelines in this area. Additionally, the Council is surveying other state medical associations and organizations for guidelines they may have developed in this area.

The Council is honored to serve the Association and urges that all members continue to recognize their responsibility, not only to patients, but also to society, to other health professionals, and to themselves.

William P. VonderHaar, MD
Chair

Report of the Physician-Attorney Liaison Committee

The Physician-Attorney Liaison Committee continues to address complaints between the two honored professions.

Although the Committee did not formally meet during the past year, it continues its efforts to resolve differences between physicians and attorneys and to improve their professional relationships.

The Interprofessional Code continues to be published periodically in the *KMA Journal* and the *KBA Bench and Bar*. Comments are welcomed from both professions as to how the Interprofessional Code may be updated and improved. The Committee is also obtaining the opinion of an antitrust attorney as to whether it can continue to review deposition fee complaints and issue to the parties opinion letters regarding the appropriateness of said fees.

The Committee continues to receive complaints received from Kentucky physicians regarding attorney advertisements about medical malpractice. It was the consensus of the Committee that it was powerless to prevent this type of advertisement or similar advertisements due to a recent United States Supreme Court decision concerning professional advertising.

The Committee continues to study ways to improve the relationship between physicians and attorneys. Joint seminars, joint articles, and formation of a speakers' bureau are several of the options available to the Committee.

The Committee thanks the House of Delegates for the opportunity to serve and looks forward to fulfilling its objectives in the coming year.

Lynn L. Ogden, MD
Co-Chair

END OF CONSENT CALENDAR ITEMS

Report of the Committee on Maternal and Child Health

The Committee on Maternal and Child Health conducted two meetings during the 1993-94 Associational year. In its initial meeting, the Committee considered a referral from the 1993 House of Delegates, involving the following recommendation from the Committee's 1993 Final Report. In this Committee's 1993 final report to the House of Delegates, the following recommendation was included in the report.

> Recognizing the importance of preventive health for all infants and children in the Commonwealth, the Committee on Maternal and Child Health recommends that all high-risk newborns eligible for Medicaid be visited by public health nurses to assure metabolic screening, access to a primary care provider, infant immunizations, access to the WIC program where indicated, implementation of application for newborns under Medicaid, and repeat pregnancy education.

A letter from the Committee Chair, which included the KMA recommendation, was mailed to the Secretary of the Cabinet for Human Resources, Commissioner of the Department for Health Services, and Commissioner for the Department for Medicaid Services.

Committee member Ronald J. Lubbe, MD, provided members with an Executive Summary of the March of Dimes' Committee on Perinatal Health report which makes recommendations for the regionalization of perinatal care in the 1990s and beyond. Dr. Lubbe informed the Committee that the Kentucky Perinatal Association and the state's two medical schools have made this report an issue and are interested in forming a coalition to discuss the document and determine whether or not to adopt it as a model. The document has also been introduced to the Kentucky Pediatric Society for its review and consideration in becoming a part of the coalition. The Executive Summary listed 10 essential recommendations for improving the outcome of pregnancy:

1. Health Promotion and Health Education
2. Reproductive Awareness
3. Structure and Accountability
4. Preconception and Interconception Care
5. Ambulatory Prenatal Care
6. Inpatient Perinatal Care
7. Infant Care
8. Improving the Availability of Perinatal Providers
9. Data, Documentation, and Evaluation
10. Financing Perinatal Care

In an effort to determine how the Committee on Maternal and Child Health could help implement the above recommendations, discussion ensued regarding the curriculum in Kentucky's elementary schools. Interest was shown in determining the health education curriculum now being utilized in local districts and KERA requirements. The Department of Education was contacted regarding this issue. Prior attempts by the House of Delegates and the Committee on School Health, Physical Education, and Medical Aspects of Sports regarding mandatory health education in schools were researched and reported to the Committee. With the adoption of KERA, the Kentucky General Assembly removed all statewide mandates and allowed local systems to adopt curriculum. The Department of Education responded to the Committee's questions and, while indicating that students were tested for health education concepts, it was noted that there is no mandate to teach health education. The Committee discussed the possibility of forming a coalition to advocate health education in schools. It was also stressed that the Committee's major area of concern is in the field of prenatal care and the Committee is very concerned that women and children receive appropriate health care.

Third-party payors seem to be placing increasing pressure on physicians to discharge newborns and their mothers early. One major Kentucky health insurer has issued a letter encouraging discharge the day following delivery, with follow-up through a home health service. The Committee undertook to address this issue, recognizing the potential problems that could possibly result if time of discharge is determined on the basis of nonmedical factors.

Copies were distributed of a report of the Wisconsin Association for Perinatal Care which recommends certain quality of care standards be met prior to hospital discharge of mother and newborn. The following steps are utilized to decrease morbidity in mothers and children and as a method of negotiating with third-party payors.

> All patients should have a case manager, be it the patient herself, the primary care provider, public health nurse, tertiary care provider, or some other advocate or support person.
>
> Hospital staff should be expected to accomplish the following goals during the time they have with the patient during the intrapartum and postpartum periods:
>
> - The physiological stability of the mother and infant.
> - An intact feeding interaction.
> - Patient education on how to care for herself and her baby, and when and how to contact her care provider.
>
> A physician-directed referral source of continuing medical care for both mother and baby should be identified and arrangements made for the baby to be examined within 48 hours of discharge.
>
> The following assessments should be performed on all infants/families prior to discharge:
>
> - Parents' concerns, priorities, and resources

- Developmental/sensory risk assessment
- Maternal/infant interaction
- Psychosocial
  - Parenting readiness
  - Home environment
  - Financial needs

A formal discharge plan should be developed for each infant/family.

Care conferences should be convened for infants/families that have a variety of needs/concerns.

Standard interagency referral and communication forms should be considered as a way to communicate the same information to multiple providers, patient support personnel, and the family.

Each community should have an MCH committee that can study the needs of infants and families and advocate for the resources and policies that are needed to serve them.

Health care providers and payors should work together and have a common understanding about which patients fall within their managed care guidelines for each discharge and which patients are outliers.

The Committee on Maternal and Child Health recommends that the KMA House of Delegates endorse the guidelines established in the report by the Wisconsin Association for Perinatal Care. The Committee would like to emphasize that this is not to be interpreted as an endorsement of early discharge for all mothers and infants. In some instances early discharge may be appropriate, and in other instances it may not be. The guidelines delineated in this report will help the physician arrive at that decision which will be in the best interest of the mother and child.

The Committee regrets that Pat Nicol, MD, Director, Division of Maternal and Child Health, is retiring. The Committee will miss her presence and guidance and commends her for 40 years of service to the mothers and children of Kentucky and her long and active participation in this Committee's work. She will be missed.

J. Gregory Cooper, MD
Chair

RECOMMENDATIONS:

1. The Committee on Maternal and Child Health recommends the adoption of guidelines for hospital discharge of mother and newborn established by the Wisconsin Association for Perinatal Care.

Recommendations, Reference Committee 5:

Reference Committee No. 5 reviewed the Report of the Committee on Maternal and Child Health and its Recommendation No. 1 dealing with the guidelines for hospital discharge of mother and newborn established by the Wisconsin Association for Perinatal Care and heard testimony from the chair of the Maternal and Child Health Committee.

Mr Speaker, the Reference Committee recommends the adoption of the Report of the Committee on Maternal and Child Health and its Recommendation No. 1. Reference Committee No. 5 further recommends that a copy of the information contained in the guidelines addressed in Recommendation No. 1 be disseminated to individuals and institutions involved with obstetrics and newborn care.

Report of the Committee on Community and Rural Health

The Committee on Community and Rural Health met on two occasions this year and the Subcommittee on Domestic Violence, which reports to the Committee, met on one occasion.

The Committee reviewed the Kentucky Board of Medical Licensure regulation on HIV/HBV infection control for physicians which became effective on October 13, 1993. The development of the regulation was prompted by a federal requirement — Public Law 102-141 — for each state to implement the Centers for Disease Control recommendations for preventing the transmission of HIV/HBV during the performance of significant risk procedures. The regulation calls for "a physician who is HIV or HBV seropositive and e antigen positive, and who performs patient care procedures which pose a significant risk of transmission of HIV/HBV to patients, may seek counsel from the Kentucky Board of Medical Licensure." The regulation further spells out that if the physician seeks counsel, the Licensure Board may convene a review panel to monitor the physician's clinical competency. The review panel will include the primary care physician of the HIV- or HBV-positive physician, a clinical infectious disease specialist, and a state epidemiologist. The regulation provides for confidentiality under the Kentucky Board of Medical Licensure. As a result of the new regulation becoming effective, the Committee submitted an article to the "Communicator" notifying all members of the regulation, and the official contact person at the Kentucky Board of Medical Licensure.

Several other items were discussed regarding the issue of HIV infection. The Committee reviewed information on guidelines from the US Department of Health and Human Services of management of HIV infection. After reviewing the information, the Committee felt that it should be made known to Kentucky physicians. As a result, an article was submitted to the "Communicator" about the availability of the information through the US Department of Health and Human Services.

In addition to the guidelines from the US Department of Health and Human Services, the Committee discussed the need to have current information about HIV infection available to physicians in the form of slides for presentations. The Committee will work with the Department for Health Services and the University of Kentucky to coordinate current information on HIV infection for the development of a slide presentation for physicians.

The Committee reviewed a request from the Kentucky Center for Health Education and David T. Allen, MD, regarding various levels of endorsement from the Kentucky Medical Association. The Kentucky Center for Health Education is proposing to offer a range of educational activities for school groups on health and safety issues like drug abuse, driving while under the influence of alcohol, and effects of tobacco. While the Committee had concerns that the Center may not serve a statewide audience with its headquarters in Louisville, the Committee was in favor of the concept and forwarded a recommendation to the KMA Board of Trustees to endorse the concept of the Kentucky Center for Health Education. The Committee recommended that before any further support is requested from physicians, the personnel involved in the development of the Kentucky Center should compile a business plan of scientific data demonstrating the effectiveness and impact that similar Centers for Health Education in other states have had on the health of their communities. It was decided that a letter from the Chair of the Committee and the KMA President should be sent to David T. Allen, MD, encouraging him to show what effects the Center would have on the health of Kentucky citizens.

Clarkson Palmer, MD, and Reginald Finger, MD, Department for Health Services, updated the Committee on the Vaccine For Children program. The Department for Health Services has held forums around Kentucky to solicit physician input on the development of the program. Another purpose of the forums was to register physicians into the programs. Forms are being made available to primary care physicians including provider enrollment forms, provider profile sheets, vaccine order forms, patient eligibility screening record forms, and quarterly vaccine report forms.

A state registry is also in the planning stages through the Cabinet for Human Resources. The registry is expected to be in operation by 1995 and will enable the Cabinet for Human Resources to track children in the state for immunization purposes. The goal of the program is to have every child immunized in Kentucky.

The Committee reviewed policy from the medical schools regarding HIV-positive students. At the request of Reference Committee No. 5 at the 1993 House of Delegates, "the KMA was to secure information from Kentucky's medical schools as to their policies regarding HIV-positive students, their subsequent dismissal, and what opportunities are available for counseling, career modification advice, and other assistance; and that this information be referred to the appropriate committee for review and possible recommendation." After considerable review by the Committee, it was recommended that a letter be forwarded to the Deans of the medical schools encouraging them to include in the medical school policy on HIV-positive students a section for counseling and career modification that is similar to the regulation recently passed by the Kentucky Board of Medical Licensure that provides for counseling and career modification by an expert review panel for HIV-positive licensed physicians in Kentucky. The Licensure Board regulation provides for a panel composed of the HIV/HBV-positive physician's primary care physician, an infectious disease specialist, and a state epidemiologist.

The "Blue Ribbon" Subcommittee on Domestic/Interpersonal Violence, chaired by Baretta R. Casey, MD, met on February 15, 1994, to review

current issues regarding domestic violence. The Subcommittee was charged with recommending to the Kentucky Medical Association methods to improve physician education in order to better deal with the complex problem of domestic/interpersonal violence. The Subcommittee developed an educational packet which was sent to all physicians in Kentucky in September 1993. The packet consisted of a state map with locations and phone numbers of all spouse abuse centers in the state, a child abuse brochure, an adult/elderly abuse brochure, and a separate patient brochure. The packet also included an order form for requesting additional educational packets. Due to the demand, a reprinting of the packets was done and sent to those requesting brochures. The packets were also sent to county medical societies, all health departments, coroners, and hospital emergency rooms. The child abuse brochures were sent to all Kentucky public and private schools and day care centers.

The Subcommittee oversaw the implementation of Resolution E from the 1993 KMA House of Delegates. Resolution E asked that KMA urge Kentucky's medical schools to adapt their curriculum to include training for domestic violence cases including recognizing and reporting abuse, proper techniques for interviewing and diagnosing patients, and proper documentation of abuse of the patient. After a letter was sent to the Deans of both medical schools encouraging them to implement domestic violence awareness training in the curriculum, each responded to the Subcommittee with specific course curriculum training where domestic violence identification and diagnosis were being performed.

The Subcommittee has met both its short- and long-term goals including:

Short-term goals
- — Educate physicians on the problem of domestic violence.
- — Instruct physicians on the present laws in Kentucky as they relate to reporting known and suspected domestic violence.
- — Educate communities by providing brochures to physician offices, hospitals, and other public places.

Long-term goals
- — Recommend that medical schools in Kentucky implement courses on diagnosing abuse victims.

The Subcommittee explored ways to continue to educate physicians on domestic violence issues and felt that a day-long seminar with national speakers on domestic violence issues would be effective in helping physicians understand the complexities of the problem. As a result, the Subcommittee has scheduled a seminar on domestic/interpersonal violence awareness to be held on October 22, 1994. The Subcommittee is currently working on getting nationally known experts to discuss important medical topics relating to domestic violence.

Another initiative of the Subcommittee is to work closely with the Attorney General's Office in development of guidelines of model policy and procedure for hospitals and physicians' offices for identification and reporting of domestic violence in patients. The Subcommittee's work in this area will be on an ongoing basis.

We thank the KMA Board of Trustees for being permitted to serve.

Edmond A. Hooker, MD
Chair

RECOMMENDATIONS:

1. The Committee recommends that the Kentucky Medical Association draft a letter to The Kentucky Center for Health Education and David T. Allen, MD, asking him to outline the benefits that the Center will have on the health of the community and include scientific data for supporting evidence.
2. In response to the request of Reference Committee No. 5 at the 1993 House of Delegates, the Committee recommends a letter be sent to the medical schools encouraging them to add a section to their policies on HIV infection in students that allows for adequate counseling and career modification similar to the regulation of the Kentucky Board of Medical Licensure on HIV/HBV infection control.

Recommendations, Reference Committee 5:
Reference Committee No. 5 reviewed the Report of the Committee on Community and Rural Health and its Recommendations. The Reference Committee would like to thank the chair and committee members for their work during this Associational year.

Mr Speaker, Reference Committee No. 5 recommends that the Report of the Committee on Community and Rural Health and its Recommendations 1 and 2 be adopted.

RESOLUTION E

Kentucky Organic Growers
Estill County Medical Society

WHEREAS, Kentucky families are increasingly interested in a healthy lifestyle, including a low-fat, high-fiber diet emphasizing fruits, vegetables, grains, and legumes; and are especially concerned about protecting their children from pesticide residues in food; and

WHEREAS, Kentucky farmers recognize the need for alternative cash crops to replace tobacco and need help creating new markets with a guaranteed income; and

WHEREAS, Kentucky physicians want to protect the public health from the effects of tobacco, also want to protect our farmers from a declining tobacco market, and are concerned about research suggesting links between pesticides and human disease; and

WHEREAS, Kentucky Organic Growers is a new pilot program of the Burley Tobacco Growers' Cooperative Association creating a direct connection between consumer families and family farmers growing alternative cash crops minimizing use of harmful chemicals (beginning with organic fruits and vegetables); and

WHEREAS, the Kentucky Academy of Family Physicians applauds the foresight of the Burley Tobacco Growers' Cooperative Association in creating Kentucky Organic Growers, and adopted a similar Resolution at its 1994 annual meeting; now, therefore, be it

RESOLVED, that the Kentucky Medical Association communicate directly with the leadership of the Burley Tobacco Growers' Cooperative

RESOLVED, that the Kentucky Medical Association urge Kentucky physicians, clinics, hospitals, medical societies, and other medical entities to assist Kentucky Organic Growers at this pivotal time by supporting Kentucky agriculture in the post-tobacco era.

Recommendations, Reference Committee 5:
Reference Committee No. 5 reviewed Revised Resolution E, introduced by the Estill County Medical Society, and heard considerable comments from the audience, including testimony from the Kentucky Academy of Family Physicians, which recently passed a similar resolution.

Mr Speaker, the Reference Committee recommends adoption of Resolution E.

Don R. Stephens, MD, Chair, Board of Trustees, was recognized. Dr Stephens made a motion, on behalf of the Board of Trustees, that the final phrase in the last Resolved; ie, "in the post-tobacco era," be deleted.

The motion was seconded from the floor and carried.

RESOLUTION L

Regulatory Agencies
Jefferson County Medical Society

WHEREAS, "regulatory" agencies are operating in this Commonwealth without restraint and without concern for the cost-effectiveness of their regulations; and

WHEREAS, these agencies pass regulations on to nursing homes and home health agencies that require considerable amounts of physicians' time; and

WHEREAS, these agencies seldom, if ever, consult with physicians or physician organizations about the impact of their regulations on patient care; and

WHEREAS, Resolution 1 (1993) resolved that the KMA gather information and establish a committee or use an existing committee to evaluate how state and federal regulations for nursing homes, home healthcare providers, and healthcare supply vendors adversely impact on physicians' time, professional judgment, and the cost of health care; and

WHEREAS, Resolution 1 (1993) further resolved that the KMA ask the AMA for national input, guidance, and action regarding state and federal regulations for nursing homes, home health care providers, and healthcare supply vendors which increase the cost of care and interfere with the physician-patient relationship and the physician's exercise of professional judgment; now, therefore, be it

RESOLVED, that the Kentucky Medical Association investigate regulations imposed on nursing homes and home health agencies as to their merit in patient care, their intrusion into providers' time, and their increase in health care costs; and be it further

RESOLVED, that the KMA reaffirm 1993 Resolution I and direct that a progress report on the implementation of Resolution I (1993) be presented to the Board of Trustees.

Recommendations, Reference Committee 5:
Reference Committee No. 5 reviewed Resolution L, Regulatory Agencies, introduced by the Jefferson County Medical Society, and heard testimony from several members, including Harold Haller, MD, author of the Resolution, who spoke of the many regulations concerning nursing homes and home health agencies being placed on physicians without any consideration of or consultation with physicians or healthcare organizations about the impact of those regulations on patient care. Doctor Haller noted that Resolution I, passed by the House of Delegates in 1993, also asked KMA to investigate regulations imposed on nursing homes and home health agencies.

Mr Speaker, Reference Committee No. 5 recommends the adoption of Resolution L. The Reference Committee further recommends that Resolution L be implemented with more enthusiasm than was given to Resolution I (1993).

RESOLUTION M

Practice Environment in Kentucky
Fayette County Medical Society

WHEREAS, the Commonwealth of Kentucky has levied a 2% tax on the gross income of physicians, ostensibly to help fund Medicaid; and

WHEREAS, the Commonwealth of Kentucky has transferred $131 of Medicaid money into the General Fund; and

WHEREAS, the Secretary of Human Resources has threatened a unilateral decrease in Medicaid allowable fees that have been in place since July 1991; and

WHEREAS, the reduction in Medicaid fees will decrease the access of indigent patients to care; and

WHEREAS, a reduction in Medicaid fees will impact most adversely physicians whose practices consist principally of indigent patients and thereby penalize those who provide the bulk of the care the Commonwealth of Kentucky supposedly desires to enhance; now, therefore, be it

RESOLVED, that if the Commonwealth of Kentucky accomplishes a unilateral decrease in Medicaid payment for physician services, the Kentucky Medical Association emphatically and enthusiastically pursue all reasonable options to address this inequity; and be it further

RESOLVED, that the KMA declare the current legislative and administrative environment in Kentucky punitive to physicians and counterproductive to reliable, appropriate, and adequate health care for the indigent; and be it further

RESOLVED, that the KMA make known to individuals contemplating the establishment of medical practice in this Commonwealth the existence of the current hostile environment.

Recommendations, Reference Committee 5:
Reference Committee No. 5 next reviewed Resolution M, Practice Environment in Kentucky, introduced by the Fayette County Medical Society.

There was considerable testimony concerning this Resolution with the major focus of discussion being on the third "Resolved."

The Reference Committee heard testimony that inclusion of the third "Resolved" would be deleterious to recruitment and retention efforts of physicians. Although the intent of the "Resolved" is understandable, the Committee believes the impact on Kentucky physicians would be negative. The majority of those speaking, while in favor of the Resolution, were opposed to the third "Resolved."

The Reference Committee, therefore, recommends that Resolution M be amended by the deletion of the third "Resolved."

Mr Speaker, Reference Committee No. 5 recommends the adoption of Resolution M, as amended.

The motion was seconded from the floor and carried following a lengthy discussion.

Resolution M, adopted as amended, reads as follows:

RESOLUTION M
(Adopted as amended)

Practice Environment in Kentucky
Fayette County Medical Society

WHEREAS, the Commonwealth of Kentucky has levied a 2% tax on the gross income of physicians, ostensibly to help fund Medicaid; and

WHEREAS, the Commonwealth of Kentucky has transferred $131 million of Medicaid money into the General Fund; and

WHEREAS, the Secretary of Human Resources has threatened a unilateral decrease in Medicaid allowable fees that have been in place since July 1991; and

WHEREAS, the reduction in Medicaid fees will decrease the access of indigent patients to care; and

WHEREAS, a reduction in Medicaid fees will impact most adversely physicians whose practices consist principally of indigent patients and thereby penalize those who provide the bulk of the care the Commonwealth of Kentucky supposedly desires to enhance; now, therefore, be it

RESOLVED, that if the Commonwealth of Kentucky accomplishes a unilateral decrease in Medicaid payment for physician services, the Kentucky Medical Association emphatically and enthusiastically pursue all reasonable options to address this inequity; and be it further

RESOLVED, that the KMA declare the current legislative and administrative environment in Kentucky punitive to physicians and counterproductive to reliable, appropriate, and adequate health care for the indigent.

RESOLUTION T

Discount Option Program (DOP)
Fayette County Medical Society

WHEREAS, the Discount Option Program (DOP) represents a form of rate fixation which Kentucky physicians consider to be unconstitutional; and

WHEREAS, Kentucky physicians have already demonstrated their good faith to provide health care to the indigent by voluntary participation in Governor Jones' Health Care Access Foundation through which FREE care is given; and

WHEREAS, Kentucky physicians will continue to provide free care in their individual practices to those truly indigent as they have traditionally done in the past; and

WHEREAS, current Medicaid reimbursement fee schedules (ie, DOP equivalent) are already less than fair and appropriate; and

WHEREAS, the present state administration is planning to decrease reimbursement of Medicaid further, even though the program had in excess of $130 million transferred to the general state fund; and

WHEREAS, the DOP is NOT a Medicaid program, so the state government has no fiscal responsibility in this matter; and

WHEREAS, the DOP will be counterproductive to have universal access to providers due to the dropout rate of physicians from the Medicaid program; now, therefore, be it

RESOLVED, that the Kentucky Medical Association work with the administration and legislators to rescind this program (DOP); and be it further

RESOLVED, that KMA monitor the number of physicians who elect not to participate in the DOP and make the information available to physicians and the public; and be it further

RESOLVED, that the legal and constitutional appropriateness of the DOP be investigated.

RESOLUTION V

Discount Option Program
KMA Board of Trustees

WHEREAS, HB 250 directs the Cabinet for Human Resources (CHR) to establish "a program as a provider of last resort which permits persons with a family income below 200% of poverty TO PURCHASE THROUGH THE MEDICAID PROGRAM health services covered by Medicaid from participating providers at the same rate Medicaid pays for the service . . . "; and

WHEREAS, the CHR-designed Discount Option Program (DOP) violates HB 250's directive that the program be a "provider of last resort" by permitting individuals who also have private insurance to be eligible; eliminates all cost sharing mechanisms; and for certification purposes, considers very

limited information and allows individuals with substantial assets to qualify beyond the intent of HB 250; and

WHEREAS, providers who participate in Medicaid are required to participate in DOP under the threat of a $500.00 fine per violation; and

WHEREAS, as a result of the DOP many physicians who render medical care to limited numbers of Medicaid patients, particularly indigent elderly patients covered by both Medicare and Medicaid, may no longer be able to see those patients if the physician chooses to not participate in the DOP program; now, therefore, be it

RESOLVED, that the KMA officially notify the leadership of the General Assembly and the Administration of Governor Jones that the DOP places enormous financial and legal risks upon participating physicians; and be it further

RESOLVED, that KMA contact the Health Care Financing Administration and inquire as to the legality of a nonfunded state program determining whether a provider can or cannot participate in federally funded programs such as Medicare and Medicaid; and be it further

RESOLVED, that if the DOP program is officially implemented that KMA research and take appropriate action regarding its constitutionality under both state and federal constitutions; and be it further

RESOLVED, that the KMA communicate with every physician member outlining the DOP, stringent penalties for violations, and mandated participation if the physician treats Medicaid patients and patients with Medicaid and Medicare.

Resolution T, Discount Option Program (DOP), introduced by the Fayette County Medical Society, and Resolution V, Discount Option Program, introduced by the Board of Trustees, were considered together because of the subject matter. The Reference Committee was provided with additional information about the Discount Option Program.

Mr Speaker, Reference Committee No. 5 recommends that Resolution V be adopted in lieu of Resolution T.

Mr Speaker, Reference Committee No. 5 recommends the adoption of the report of Reference Committee No. 5 as a whole, as amended.

Mr Speaker, I would like to thank the other members of this Committee, Magdalene B. Karon, MD, Lexington, Lucian Y. Moreman, MD, Elizabethtown; John M. Patterson, MD, Frankfort; Susan H. Prasher, MD, Ashland; and Michael Pulliam, MD, Franklin, for their time and thoughtful consideration of the issues referred to the Reference Committee. The Chair would also like to thank Doris Crume for her assistance in the preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE NO. 5
Vaughn W. Payne, MD, Louisville, Chair
Magdalene B. Karon, MD, Lexington
Lucian Y. Moreman, MD, Elizabethtown
John M. Patterson, MD, Frankfort
Susan H. Prasher, MD, Ashland
J. Michael Pulliam, MD, Franklin

Election of Officers

James E. Redmon, MD, Louisville, Chair of the Nominating Committee, presented the slate of nominees for offices as follows:

President-Elect	Danny M. Clark, MD Somerset

Dr Clark was elected by acclamation, and escorted to the podium by Past Presidents Donald C. Barton, MD, and Preston P. Nunnelley, MD.

It was noted that Dr Clark's election as President-Elect would leave one year remaining in his current term as Speaker, House of Delegates. Nominated to the position of Speaker, House of Delegates, was C. Kenneth Peters, MD, Jeffersontown. Dr Peters was elected by acclamation.

Following Dr Peters' elevation to Speaker, House of Delegates, nominations were accepted to fill the one year remaining in Dr Peters' term as Vice Speaker. Nominations were received for John W. McClellan, MD, Henderson, and Thomas K. Slabaugh, MD, Lexington. Following a written ballot, it was announced that Dr McClellan had been elected Vice Speaker, House of Delegates.

Dr Redmon then presented the remainder of the slate of nominees, and each was elected by acclamation.

Vice President	William H. Mitchell, MD Richmond
Delegate to the AMA (1/1/95-12/31/96)	Wally O. Montgomery, MD Paducah
Delegate to the AMA (1/1/95-12/31/96)	Robert R. Goodin, MD Louisville
Delegate to the AMA (9/21/94-12/31/96) (new position)	Donald J. Swikert, MD Florence
Alternate Delegate to the AMA (1/1/95-12/31/96)	Bob M. DeWeese, MD Louisville
Alternate Delegate to the AMA (1/1/95-12/31/96)	Preston P. Nunnelley, MD Lexington
Alternate Delegate to the AMA (9/21/94-12/31/96) (new position)	William B. Monnig, MD Edgewood
Alternate Delegate to the AMA (9/21/94-12/31/95) (to finish unexpired term of Donald J. Swikert, MD)	G. Irene Minor, MD Berea

Dr Redmon then submitted the following nominations for the offices of Trustees and Alternate Trustees on behalf of the Trustee District nominating committees, and each was elected by acclamation:

2nd District Trustee	Donald R. Neel, MD Owensboro
2nd District Alternate	Joseph H. Harpole, MD Henderson
7th District Trustee	Ronald E. Waldridge, MD Shelbyville
7th District Alternate	John M. Patterson, MD Frankfort
9th District Trustee	Donald R. Stephens, MD Cynthiana
9th District Alternate	Robert L. McKenney, MD Falmouth
10th District Trustee	Russell L. Travis, MD Lexington
10th District Alternate	Andrew R. Pulito, MD Lexington
13th District Trustee	Kenneth R. Hauswald, MD Ashland
13th District Alternate	Susan H. Prasher, MD Ashland

Election of 1995 Nominating Committee

The following physicians were elected by the House of Delegates to serve as the 1995 KMA Nominating Committee:

James R. Bean, MD, Lexington, Chair
James D. Crase, MD, Somerset
Joe T. Davis, MD, Bowling Green
Jayne L. Hollander, MD, Louisville
Michelle M. Murray, MD, Alexandria

Speaker Clark adjourned the 1994 Session of the KMA House of Delegates at 9:20 PM.

1994-95 KMA Committees

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Eric Lentsch, MD, Louisville (resident)
Thanai Pongdee, Lexington (student)
Ray Shaheen, Louisville (student)
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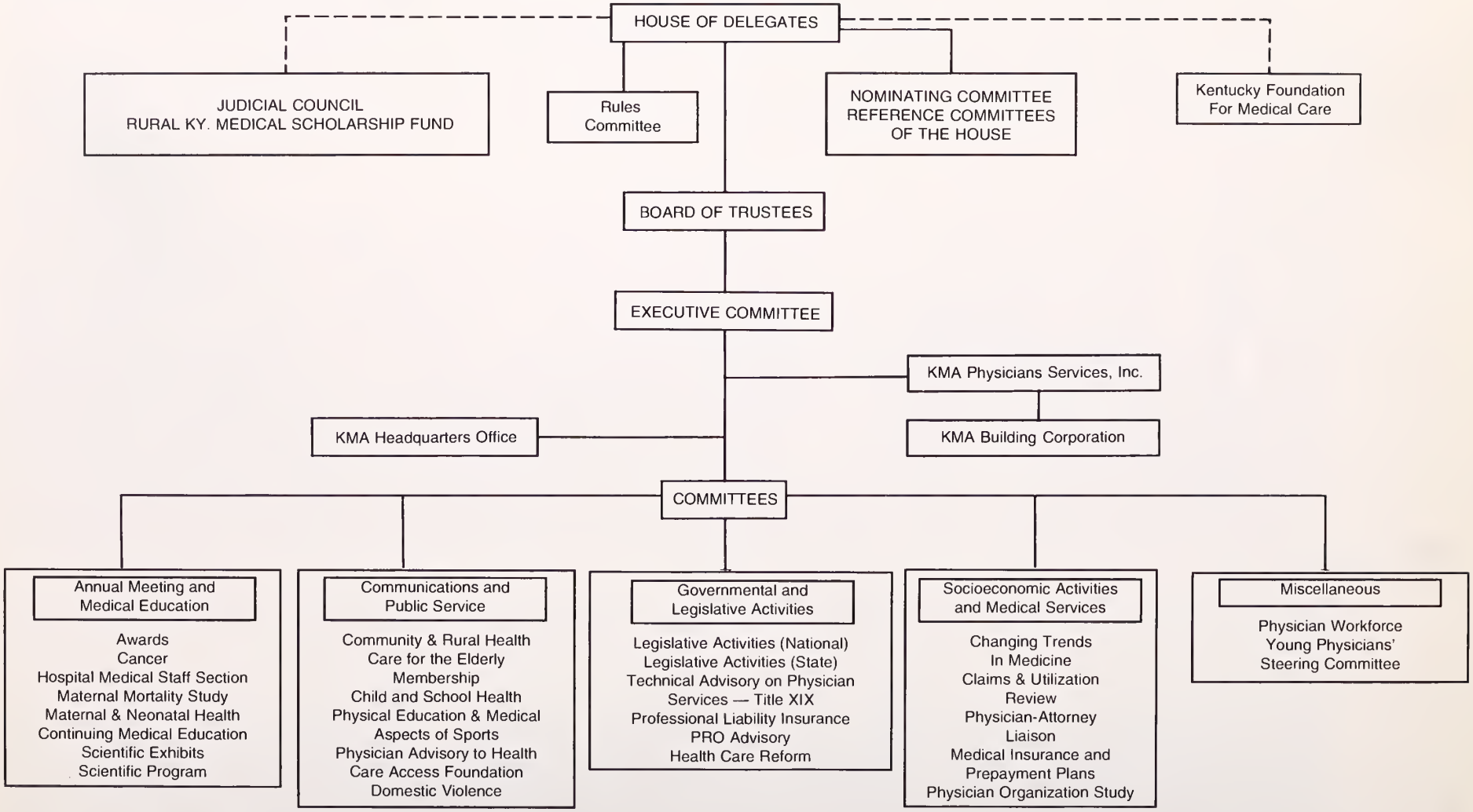
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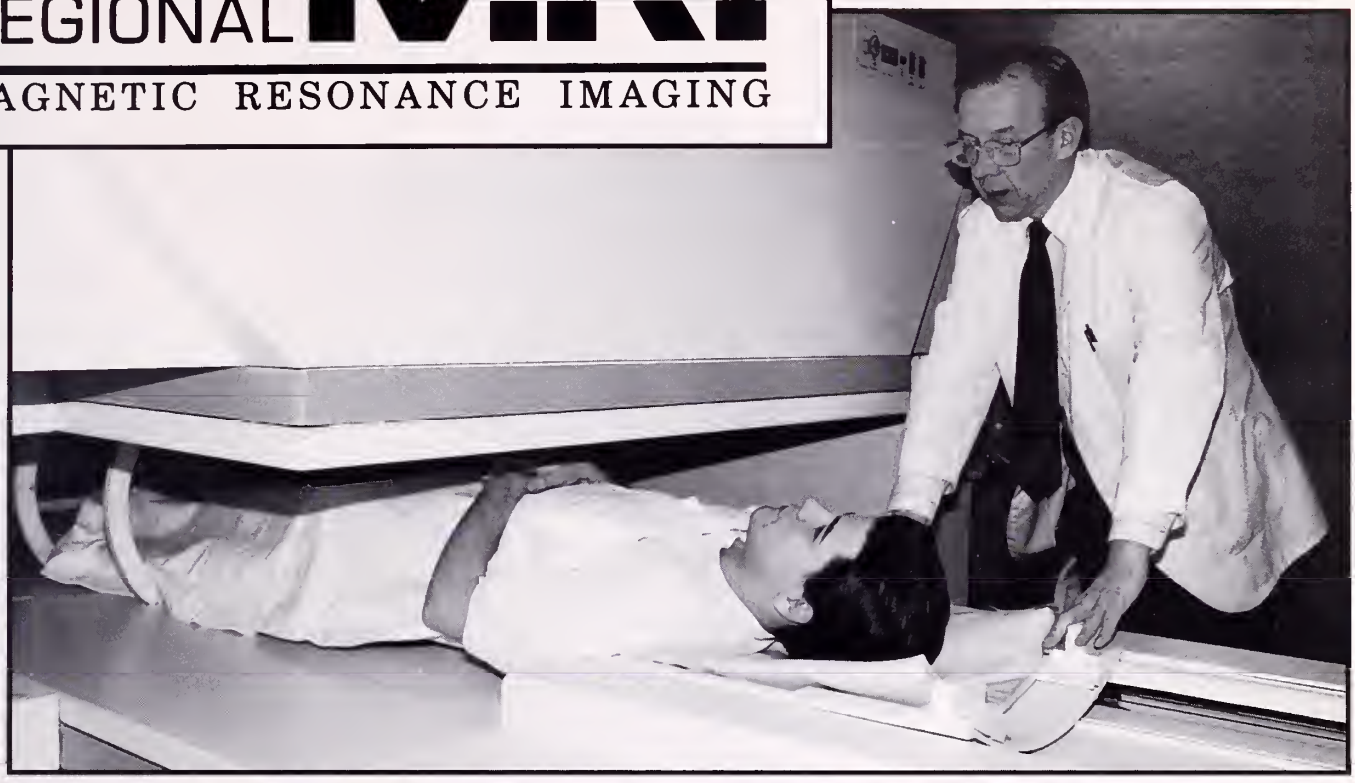
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